Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 14, 2007 **Physician** R. Levy 10:25 A.M Erica /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery 12213 Tilden Wood Drive 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min. Hours 1 M 2K F 095-26-7434 75 Director Germany September 17, 1931 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 1 X Yes 2 □ No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20852 12213 Tilden Wood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 K Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 5+ Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Laura Liffgens Leopold Levy ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 391 10th Street #3, Brooklyn, New York 11215 Stephen L. Gordon/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State ial Gardens 19, 2007 Olney, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805 August 19, 2007 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 21. Signature of Funeral Service Licensee M00335 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 9 phyxia /Medical as a consequence of): Due to (a) Solf enflicte **Examiner** an Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 \(\square\) No deaun? 1∐Yes 2.2No certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury
(Month, Day Year)

Aug 14 2007 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After Injury 1 Natural 5 Pending 1015 M 1 Tes investigation 2 ☐ Accident

The law requires that the death certificate be executed P.O. Box 68760, Records, Division or Vital To the Hospital or Attending Physician: death. within 24 hours after death To the Funeral Director: completely filled in by the

Baltimore, Maryland 21215-0036

6 ☐ Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 2 213 Tilden wood Dr Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Ome Rockville 20854 mo 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On Me basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and major stated. (Check only

29c. License number

D00428

29d. Date signed (Month, Day, Year)

MOME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2101 Medical Park Drive #304, Silver Spring, Maryland 20902 Brecher, M.D., Ira N.

State Registrar

V)

Medical

one)

29b.

nature and title of certifie

07-06190 Dav

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

von McCargo	1.	State State	of Maryland / Departi Certif	ment of li licate of l	Health and Mental Death	Reg. N	b 20	07 2650
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ours a		15. Decedent's Education (Specify o	, , ,	 6a. Decedent during mo 	's Usual Occupation (Give kind ost of working life. DO NOT use		ob. Kind of Busines	s/industry
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21215-0036 und be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	BeC	David K. 1	in cargo			Ernestin		
by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. trem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	라	19a. Informant's Name/Relationship (Type, Print)		Address (Street and Number	r or Rural Route Number	er, City or Town, St	ate, Zip Code)
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	-	23a. Part I. Enter the disease, or com	polications that caused the death. I	Do not enter t	ne mode of dying, such as care	liac or respiratory arres	t, shock, or heart	
Physician edical		failure. List only one cause on e	each line. Multiple Gunshot Wound					Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):					
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	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of)	:	130.0	*		
. 11.	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)	:				
nand ransit	a E		d					
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766 ficate g phys	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregn		etal death 3 Ectopic	oregnancy	Month	Day Year
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Division pital or Attent ours after death ceral Director:	Certification:	3 Suicide 6 Could n 4 ✔ Homicide determi		et		1300 Block of	West Lafayette	Avenue, Baltimore, MD
Hos 24 h Fun tely		29a. Certifier	sician: To the best of my knowledg	ge, death occ	urred at the time, date and pla	ce, and due to the caus	e(s) and manner as	stated.
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examin	ner:On the basis of examination at and manner stated.	nd/or investig		curred at the time, date		(Month, Day, Year)
F 3 F 8	Me	29b. Signature and title of certifier	(- ^		29c. License number		August 12, 2	
		Carde	Hallery		O.C.M.E.		August 12, 2	
ц		30. Name and address of person wh		111 Donn	Street, Baltimore, MD	21201		
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ate	O-difference of Dooth	Reg. No.			
dent'	t's Name (First, Middle,Last) Mishawn E. Miles	2. Date of Death Month Day	Year	Time of Death1300 hrs	

		or State			Certific	cate of l	Jeath					g. No.	13 T	ime of Death
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Funeral Director	5. 8	Social Security Number	6. Sex		e (In yrs. last b	irthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	N.41		th (MM/DD/YYYY)	9. Birthpla Foreign Country	
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a for		30. Name and address Melissa Brasse		ompleted cause ssistant Med	of death (Item	ner 111	Penn S	treet,	Baltime	ore, MD	21201			
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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 07:02 AM 2007 6 259 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES HOSPITAL LITEMORE Year If Under Days Hours 5. Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex last birthday **Funeral** 261-30-3898 Months Days Min. 1 M 2 DF Director 01 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No TA Completed by Funeral Director 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 3 any Injury or other traumatic event, the Medical Examiner must be n 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ndary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, s Name (First, Middle, Last, Be ပ 19b. Mailing Address (Street and Number or or Town, State, Zip Code) Place of Disposition (Name of complete Complete Place) 20a. Method of Disposition ocation - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Approximat Interval Between Onset and Death 23a. Part1. Enget the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final **Physician** J'EPTICEMIA DAYS ನೆ0 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) ☐Yes 2 ☐ No be detached 9□Unknown 9 Unknown MAYBEN, GLADYS signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CEREBRO VACCUAR ACCIDENT 3 ☐ Probably 4 A briknown 1 ☐ Yes 2 ☐ No DISEASE. Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CORONARY ARTERY CARDEDROYDRAFTY has autopsy this certificate 2 No VASCULAR DISEASE DIABETE DENDEN TRA HY PERTENSION or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ျ filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funera 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21227 2007 AVGVET MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) StAUNES BHIZKNORE BADEREDOG HOSPETAL MARYCANIA 31. Date filed (Month, Day, Year AUG 1 72 32. Registrar's Spriature State Registrar

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	1 - State Registrar		Ce	rtificate of l	Death		Reg. No. 💪 🕽	101 20000
de de	1. Decedent's Name (First, Middle, La	nst)				2. Date of De		3. Time of Death
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era		12. Was Decedent E	vor in II C 12			Specify Vec or No		e - American Indian,
5	11. Marital Status	Armed Forces?	. 13.	Was Decedent of H If Yes, specify Cuba	in, Mexican, Pue	rto Rican, etc.)	Blac	ck, White, etc.
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70 6	Walter F. McGuir	^^			Λmrz T	Dodona		
-	19a. Informant's Name/Relationship		19b. Mail	ling Address (Street		 Redond Rural Floute Numb 		State. Zip Code)
	CABMC DAT	7-101014	6701	N Ch	VOITE S	T TA	MISON	POSIS CM
	20a. Method of Disposition	11 1000	20b. Place of Disp	osition (Name of	AKCES C	Date	20c Location	City or Town, State
	1 Burial 2 Cremation 3	☐Removal from State	cemetery, cre	ematory or other plac			_	
	4 □ Donation 5 □ Other (Special		GREENN			15 2007		MORE, MD
	21. Signature of Funeral Service Lice	osee	2	22. Name and Addre	ss of Facility	ENRY W.	JENKIN	US AND SONS CO.
	, KAI	ONACO		16924 Yor		MONKT	ON, MD	21111
	23a. Part1. Enter the disease, or con	nplications that caused	the death. Do not er	nter the mode of dyin	g, such as cardi		-	Approximate
	shock, or heart failure. List only Immediate Cause (Final	y one cause on each lin	e.					interval Between Onset and Death
	disease or condition resulting in death)	_a. Pneumo	nia					Days
	Todaming in dodas,	Due to (or as	a consequence of):					
	Sequentially list conditions,	b. Sersis						Days
nel	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					
ä	Cause (Disease or Injury that initiated events	c. Necrot	izing Ente	erocolitis	5			Days
Ä	resulting in death) Last	Due to (or as	a consequence of):					
/Medical Examiner		_d.						
edi								
	IF FEMALE:	23c. If yes, outcome	pf pregnancy				23d Da	te of delivery
jar	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at		☐ Ectopic pregnancy ☐ Other (specify)	1			onth Day Year
/sic	1 ☐ Yes 2 M No 9 ☐ Unknown	9□Unknown	une or death 5					
Completed by Physician		contributing to dooth by	at not reculting in the	undarlying sound six	on in Bort I	220 Did	tobacco uso cont	tribute to the cause of death?
ρ	Part II. Other significant conditions	contributing to death be	at not resulting in the	underlying cause giv	en in Fait i.			
eq						.] '⊔	Yes 2 No	3 ☐ Probably 4 Munknown
Set						24a. Was	an 24b.	Were autopsy findings available
Ē							ormed?	prior to completion of cause of death?
ŏ	OF Man ages referred to modical					1 Yes		1 Yes 2 No
Be	25. Was case referred to medical examiner?	Hospital:		ont 3 DOA Oth	or.	eath (Check only		
2	1 Yes 2 No	1 mpatie		SIR S DOA	4 ☐ Nursing	Home 5 ☐ Res		
ü	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injui (Month, Day		Wor		28d. Describe	how injury occur	red
ati	2 Accident investigation	1		M 1 1	Yes 2 □ No		_	
Ĕ	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		ury - At home, farm, s c. <i>(Specify)</i>	treet, factory, office			Street and Numb wn, State)	ber or Rural Route Number,
ě								
al (Physician: To the best						
Medical Certification:	(Check only 2 ☐ Medical Exa	aminer: On the basis of and manner sta		investigation, in my	ppinion, death oc	curred at the time	, date and place,	and due to the cause(s)
Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signe	ed (Month, Day, Year)
	Do ch	10.	1					,
	Lettoy 15	willing M	//	D27	740		08/13/	2007
	30. Name and address of person who	o completed cause de	eath (Item 23a) (Type	e, Print)				
	Robert A. Palerm	0. M.D 0	GBMC 6701	North Cha	rles Sti	reet. Bai	ltimore	MD 21204
ite	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature					
ar	AUG 1 7 2007	fixed.	S. Gon	80				

Please Type or Print in Black Indelible Ink Figure All Copies Are Legible.

All Districtions of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 6Day 1. Decedent's Name (First, Middle, Last) Time of Death **Physician** Vear AUGUST to 2007 Deborah Montgomery /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 7 1950 Medical Cer ARUNDEL GATTMORE DREWINGTON If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F Months Days 214-56-0566 56 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r 105 Litton Dale Lane 21122 USA Funeral gonery 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: þ Specify: filed within 72 hours Hygiene. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Bakery Clerk Supermarket marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 is marked of George 0chs Anna Bauer ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Ochs - Brother 105 Litton Dale Lane, Pasadena, Maryland 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of important: If it any injury or c 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 8/17/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H 22. Cremation Society of Maryland, Inc. Williams wil 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death VAZIAN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed mung physician and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atten detached for u 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 M Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed/ 1 Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature d title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13-45149 dui 7007 pleted cause of death (Item 23a) (Type, Print) dress of person who co 0 Leu Burne 301 hospital 20161 32 Registrar's Signature 31. Date filed (Month, Day, Yea State Registrar DHMH 17 Rev 1/2001

eborah

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Month August 6, 2007 **Physician** Walter Q. Nicholas 8:30 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 3004 Winchester Way Fallston | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Nonth, Day), Year | Feb. 16, 15 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□ F Maryland Director 73 1934 220-30-6014 Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?? le markad other than "naturel", or Iteme 23a or 28e-f ehow traumatic evant, the Mudical Examinar must be motified at 1 ☐ Yes 2 No Director MD Harford **Fallston** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21047 USA 3004 Winchester Way Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white 3 ☐ Widowed 4 ☐ Divorced 156-58 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 engineer electrical 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Heelth and Mental int: If Item 27 le markad o Walter Clifton Nicholas Emma Louise Kuchling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth Ellen Nicholas/spouse 3004 Winchester Way Fallston, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any Injury or once. 4 Donation 5 □ Other (Specify) 21. Signature Funeral Service Licensee Roma Ld S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 e Director my. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Muscular set and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed inding physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical sate has been signed by the attending page 2 should be deteched for use as 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 200 No certificate 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death |Check only one 27. Manner of eath Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home Certification: To Residence 6 Other (Specify) To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours efter deat To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide Fo the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) Bol Air Margland Scott 31. Date fited (Month, Day, Year) State Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year bleton **Physician** Albert 105 A M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Hayen lome Mursin. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∏** M 2□ F Months Days unk 77 Yrs. Director 217-26-1384 Mar 20, 1930 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28e-f show ?7 is marked other than "netural", or iteme 23a or 28e-f ehov traumatic event, its Modical Expretment for multiped at Yes 2□No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3939 Penhurst Avenue 21215 Funeral IISA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education unk unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d 2 should be filed within hand Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be p-rmit. Pages 1 and 2 should be Department of Health and Menta Infloorient: If Itsm 27 is marked any injury or other traumatic averages. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haven Nursing Home 3939 Penhurst Avenue Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5聚Other (Specify) in state 21. Signatur of Funer I Service Licensee R nald S. Wa State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line eations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Urs /Medical Examiner thero seleco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physiclen and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 22 No 1 Yes 2 0 No 1 Yes 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 1 Natural 2 Accident 5 Pendina within 24 hours after death.

To the Funerel Director: All completely filled in by the fu investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: Un the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) oclophin st MARE 561 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature State Registrar 7 2007

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Poeparinent 8, Hearing and Merica 8/13/6/07, WS amend 7,8 per F.H. g872 10719/07 KRH 1. Decedent's Name (First, Middle 2. Date of Death 3. Time of Death Pitt, Jr. Day 2007 Rashied Jama1 Month **Physician** 0630 AM 31 JULY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA Sinai Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth **2**/60/107ay, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days **№** M 2□ F 218-77-3673 Yrs Md. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shany injury or other traumatic event, the Medical Examiner must be notified a once. Director Md. NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 USA 909 Belgian Avenue Apt ZB Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Black Completed by 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Infant Infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rashied Pitt, Sr. Chereif Hilton-Bev J. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Chereif Hilton-Bey Mother 3018 Thorndale Avenue, Baltimore, Md. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Greenmount Cem. 8-13-07 BALTIMORE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East Land 21202 1101 E. North Ave., Baltimore, Md. Daner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bronchopulmonary
Due to (or as a consequence of): Physician months /Medical Examiner Sequentially list conditions, and a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed? Yes 220 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0040362 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital 2401 W. BEIVEDETE AVE. O'BriEn, MD Sinai Thomas. 32 Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, AUG

2007

Baltimore md 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OWELI CTORIA AUGUST 15 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hos NORTHWEST PITAL CANTO RANDALISTOWN BALLINORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 5/5/9/35 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Sex 1 M 2 KF 216.32.3212 Months Director Maryland Usual Residence of Decedent 10a. State 10h. County 10c. Cify, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3484 Hillsmere 21207 Moad USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. College (1-4or 5+) St. of mD Social Service ocial worther 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 hachael Omes E. Sewell Sampson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State lyrene A. Powell/Husband 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 08.21.2007 Owings mills, mD 22. Name and Address of Facility Vouyhn C. Greene funerue Service 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8728 Liberty na Mondaustan mo 24133 Acute Immediate Cause (Final MYDEHRA'AL INTARCTION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to finite order cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed physician and the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as signed by the attending a IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, SECONDAR cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an performed certificate 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Thipatient ၉ 2 ER/Outpatient 3 DOA After this 27. Mannes of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif

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Registrar

State 31. Date fi

31. Date filed (Month, Day, Year)

AUG 1

ORCHNO

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32 registrar's Signature

my

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

doseti.

D19502

MONTH WAST HESPITHE CONTER PANBAUS DOWN, MARGLAND 21137

· ROY RICHARDSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day August 9, 2007 1404 hrs Medical Examine Troy Richardson 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) NA Sinai Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** oreian Hours Months Days Country) Director 30 8-31-1976 1 X M 2 F Yrs Md 213-88-4143 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a, State 1 X Yes 2 No 28a-f show s 23a or 28a-f show e notified at once. NA Baltimore Md. with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21205 USA 636 N. Kenwood Avenue 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12 Was Decedent Ever in U.S. White, etc. Examiner must be Armed Forces 1 X Never Married 2 Married Yes 2 X No 5 Yes 2X No specify: Specify: Black If Yes, Give Yaar Divorced Widowed saltimore, MD 21215-0036
mit, Pages I and 2 should be filed within 72 hoursaft
partment of Heath and Mental Hygiene
portanti: If item 27 is marked other than "natural"
ury or other traumatic event, the Medical Examine "natural" <u>چ</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) General Cleaning 12th grade Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Scott Richardson Vanessa Lonnie Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ 1726 Manna Avenue Apt. c-3, Baltimore, Mother Md Vanessa Scott 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 2 Cremation 3 Removal from State **y** Burial permit, Pages
Department of
Important: 10 8-18-07 Lansdowne, Md. Mt. Zion Cem. Donation 5 Other Specify 22. Name and Address of Facility March F.H. East 21. Sign | ure of Funeral Service License 21202 1101 E. North Ave., Baltimore, Md. Fart I. Enter the disease, or complications that caused the Math. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate interva Physician Between Onset and ailure. List only one cause on each line. Death fedical Gunshot wounds to head and lower extremities nediate Cause (Final disease aminer condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated events resulting in death) Last 18 Due to (or as a consequence of): and Physician/Medical AMENDED UNPENDED the attending physician ed for use as the burial The law requires that the death certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE Year 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <u>Р</u> 1 Yes 2 V No 3 Probably 4 signed | δ. 24b. Were autopsy findings available Completed Records, 24a. Was an s been si prior to completion of cause of autopsy performed? death? has No 1 🗸 Yes ✓ Yes 2 certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medica funeral director. Division of Vital Be Other₄ Hospital: DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this No 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury After 27. Manner of Death Subject shot Certification: FOUND: Yes 2 🗸 No within 24 hours after death

To the Funeral Director: A
completely filled in by the fun Natural Pending 1335 hrs Aug 9, 2007 Investigation 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3400 Blk Dupont Avenue, Baltimore, MD 3 Could not be Suicide determined (Specify) Local Street 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 W Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 10, 2007 O.C.M.E. (Mex 30. Name and address of person who completed cause of death (Item 23a)

State Registra

Ana Rubio MD. 31. Date filed (Month, Day Year), AUG

ORIGINAL

Assistant Medical Examiner

2007

32. Registrar's Signature

URSIEL GO

111 Penn Street, Baltimore, MD 21201

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- A - D	- J		Decedent's Name (First, Middle, Las	"					2. Date of De Month		Year	3. Time of Death
	hysicia: /Medica	1	MARY					ROSEN	JULY	22	2007	7:30A ^M
, E	xamine		4a. Facility Name (If not institution, give HEBREW HOME OF GI	REATER	WASHING		ROCK	VILLE If Under 24 Hrs.			unty of Death	
	neral ector		5. Social Security Number 6. Se 579-50-1648	х]м 2 X F	7. Age (In yrs. 94	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bin (Month, Da 04/16/		9. Birthp Coun	ace (State or Foreign try) MD
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death with the Maryland	a-f ehov		MD 10b. County MONT(OMERY	Toc. Cit	OLNEY	cation				1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
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Within Within	than be Me	ğ E	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire NOGRAPHE	*		וון	OVERNMI	FNT
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faryland 2 should be f	stic ev	0	ABRAHAM			SCHWA	RTZ	JENN	IE		ROS	SIN
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene.	Important: If item 27 is marked other than eny injury or other treumatic event, the Maonice.		19a. Informant's Name/Relationship (7 THEODORE ROSEN /				•	LANE, BET			own, State, Zip 20817	Code)
ROSEM limore, Mi Pages 1 and 2 ment of Health	r othe	Ī	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Pomoval from	20b. F	Place of Dispo	sition (Name of		Date	20c. Locat	ion - City or To	wn, State
Ross timor treent of	jury o		4 □Donation 5 □ Other (Specify)	State IIL	CEMET	ERY	07/2	4/2007		IMORE,	
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Division To the Hospital or Attending	To the Funeral Director: Affer this certificate no completely filled in by the funeral director, page	edical	29a. Certifier 11X Certifying Phyone) 2 Medical Exam	iner: On the b	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	n occurred at the tr vestigation, in my o	me, date and place, opinion, death occur	an Olney	caus (II) an	d manner as st	ated.
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			M. Mozin	ni,	MD		De	0060170		7/2	23/200	7
1.70)		30. Name and address of person who o		e of death (Iter		Print)	60170	Washin	Itan	1	
G	State Registra	-	31. Date filed (Month, Day, Year) AUG 1 7 2007	32. F	legistrar's Signa	Lightene	· ·					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 积11年少 MARK 11:00 A M AUGUST 142007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon Secours Hospital Baltimore 8. Date of Birth (Month, Day, AUG 21 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 43 Director 215-82-7385 Maryland Usual Residence of Decedent 10a State 10c. City. Town or Location 10h. County 10d. Inside City Limits 1X Yes 2 □ No Director MD N/A Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 529 S. Fulton Avenue 21223 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 XNever Married 2 Married 1 ☐ Yes 2X No Specify þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Handyman Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael J. Riley Marlene J. Beale 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark L. Riley, Jr. - son 335 Holiday Street, Fruitland, MD 21826 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 8/16/2007 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee H. Williams 22 Name and Address of Facility of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final BIZATERAZ PLEURAZ EFFASIONS **Physician** 24 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examine STAPH if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine HUDGEKINS that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MALNUTRITION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No KEPATITIS 24a. Was an autopsy performed? DRUG ABUSE INTRA-VENUUS 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

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the Funeral Director: Air death. the Hospitai within 24

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3altimore, Maryland 21215-0036

yes 1 and 2 should be filed within to Health and Mental Hygiene.

Pages 1 permit. Pages 1
Department of IImportant: If ite
any injury or ot

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

N23300

ANG-45T 14 2007

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PADEZ.

Print) BON SELOURS HUST. 2000 W. BALTUST. BALTO MD 21223



State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 **Physician** Nancy Y. Riggs August 5, 4:43 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 12709 Brunswick Lane Bowie Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 21 7 F Yrs. Director 026-28-3310 Oct 5, New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ahow other traumatic ayant, the Medical Examinar must be notified at 1 ☐ Yes 2√ No Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 20715 USA 12709 Brunswick Lane or Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after Hygiene. 1 □ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by white 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Heelth and Mental Hygiene Important: If Itam 27 is marked other tha any finury or other traumatic avant, Ital A 8 clerk retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harvey Gordon Young Phyllis Arnold ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Dwight Street Boston, MA 02118 Steven E. Riggs/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 21. Signatur Funeral Service Licensee
R rald S. Wadt, Tirector 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MĎ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myo cardi Priysician de /Medical Due to ras a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use es the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death [Check only one] examiner Other: 4 Nursing Home St. Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [29a. Certifier (Cneck only one) 1 rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8/10/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andre 31. Date filed (Moritin, 'Day, Year) 32 Begistrar's Signature State Registrar 2007

show Baltimore, Maryland 21215-0036

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ō	Phys
Division or V	Hospital or Attending Ph

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician HARRY 9:25 P ROTHENBERG AUGUST 14 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FUTURECARE CHERRYWOOD REISTERSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours 09/20/1913 93 NY 063-07-8620 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ral", or items 23a or 28a-f shov Examiner must be notified at MD BALTIMORE 1 ☐ Yes 2 X No OWINGS MILLS Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3440 ASSOCIATED WAY #403 21117 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23. Iny or other traumatic event, the Medical Examiner must by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Yes 2 □ No Yes, Give 1 ☐ Never Married 2 X Married WHITE 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ABRAHAM ROTHENBERG ROSE BIRNBAUM ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3440 ASSOCIATED WAY #403 - OWINGS MILLS, MD 21117 RUTH ROTHENBERG / WIFE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
KNESSETH ISRAEL permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 08/16/2007 ANSHE KOLK name and Address of Facility 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. SOL LEVINSON & BROS., INC. Immediate Cause (Final m boscs Imo sician disease or condition resulting in death) ledical Due to (or as a consequence of): miner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a gonsecvence of: Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown cate has been signed , page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∏ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes ZX No မှ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No after death.

I Director: A
d in by the fu 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral D

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 MD Mach ROR 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland & Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 14 2007 ear 9:45р м **Physician** NETTIE REYNOLDS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A BALTIMORE 6973 BLANCHE AVE. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 1-28-1 911 9. Birthplace (State or Foreign 5. Social Security Number 212-20-9 6. Sex 7. Age (In vrs. last birthday) **Funeral** VIRGINIA 1 □ M 2 🔽 F -20-9120 95 **Director** Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10h County 23a or 28a-f show Examiner must be notified at 1 TYes 2 □ No MD. N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must once. 21215 Funeral 6973 BLANCHE USA AVE. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HARBOR HOSPITAL HOUSEKEEPING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAUDE ESLEX 2 EUGENE HUDSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CLARENCE M. REYNOLDS (SON) 6973 BLANCHE AVE. BALTIMORE, MARYLAND 21215 20b. Place of Disposition (Name of cemetery, crematory or other place)
DRUID RIDGE CEMETERY 8-21-2007 20a. Method of Disposition 20c Location - City or Town, State 1 Burial 2 □Cremation BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) HTBNERName and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Fu Service Licensee JONATHAN D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death 23a. Part1. Enjecthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Oa v e (Final disease or c v cition resulting in death) Physician oncreation /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (of as a consequence of) Nivision or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1∐ Yes 2DXNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation I Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and the of certifier 0055171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOL K Sebastion 3023 taltern

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Serdel August 1T, 2007 **Physician** Lrvin 8:00 A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Ivy Hall Geriatric & Rehab. Center MIddle River If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 21, 1925 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Maryland Director 220-14**-**6519 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow other traumatic event, the Mudical Exercities reget by notified at 1 ☐ Yes 2 No MD Baltimore Essex Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With 21221 336 Sassafras Road United States or items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: à WWII 3 Widowed 4 Divorced Year or Dates: "naturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rany injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Law Enforcement 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ida Helmbold Seidel Christopher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gloria Seidel, Wife 336 Sassafras Road, Baltimore, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 【Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Portland Cremation Center | 08/16/2007 Portland, Oregon 21. Signature of Fune al 5 rv en Licensee 22. Name and Address of Facility Harman Funeral Service, P.A. M01113 7221 Grayburn Drive, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) yo cardi Privsician /Medical Due to (or as a consequence of): Examiner Loronar Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examiner ng physician and as the burial-transit the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day detached for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? рe 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 2 No of or Attending Physicien: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: Nursing Home 5 Residence 6 Other (Specify) ဥ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel within 24 hours a To the Funeral C Hospitel l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD D0061907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore MD 21221 Avenue Ebo hukwumo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-f per me 2870,08/16/07dhb

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 0150 AM Lester Edward Stickel July 26 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St AGNES HOSPITAL LITEMORE 8. Date of Birth (Month, Day, Year) 12/14/1918 Social Security Number If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 M 2 □ F 213-09-6116 88 Yrs Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Maryland n/a Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 588 Lucia Avenue USA 21229 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2**X** No Specify. ģ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Soap cutter Mfa. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ith and Mental h Be Bernard Stickel Hilda Marie Huff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 5631 Railroad Avenue, Elkridge, Maryland 21075 Karen L. Stickel / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Bayview Crematory 7/27/2007 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Nuneral Service Licenses 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATEON **Physician** PNEUMONETES /Medical Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ OBSTRUCTIVE PULMONARY DELEASE, 1 Yes 2 No 3 Probably 4 Unknown Completed FEBRUATION, SUB DURAL HEMATOMA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an DEMENTEA. CHRONEC KIDNEY 2 No 1∐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) 1 Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 No 2 Accident 3 Suicide Unknown^M Probable Multiple Falls Unknown within 24 hours after death

To the Funerai Director:
completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Unknown Unknown 1 We certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21227

State Registrar HOGPETAL, 900-1. CATON AVE.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jt Manes
32. Registrar's Signatur

BAPEREDOE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Mary		tificate of			No 2007	26519
1	Physici	an	Decedent's Name (First, Middle, Last	st)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Helen Marie Sac					August 4	, 2007	5:45 AM M
	Examin	er	4a. Facility Name (If not institution, give				r Location of Deat	h	4c. County of Dea	
			13302 Colonial 1 5. Social Security Number 6. S		yrs. last birthday)	Ocean If Under 1 Year		8. Date of Birth	Worcest	thplace (State or Foreign
	Funeral Director			□ M 2 1 8	V	Months Days	Hours Min.		ear) Co	yland
	/land		10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
	Mary	호	MD Worcest	er	0cea	n City				1 ☐ Yes 2 X No
	th the	je	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
	23a 23a	Funeral Director	13302 Colonial 1	Road			21842		USA	
	ep .	n n	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. \	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland at Hydlene and the Hydlene of other then "natural", or iteme 23a or 28a-f ehow event, the Medical Esaminar must be notified at	5	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Tyes 2 M No If Yes, Give Year or Dates:		☐ Yes 2🌠 No	Specify:		Specify: W	hite
5-	72 h natu	ete	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	16a. Deced	lent's Usual Occup kind of work done OO NOT use retired	ation during most of wo	rking unk 16	b. Kind of Business	/Industry unk
12	withir	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	iiie. L	OO NOT use retired	2)			
р 5	Hygle ther ther	ပိ	unk 17. Father's Name (First, Middle, Last)	ınk			18. Mother's Nar	me (First, Middle, Ma	iden Sumame)	
an	d be ental	To Be	Luther Bier				Helen	n Hungerfo	rd	
ar _V	shou and M mar	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or Ri	ıral Route Number, C	City or Town, State,	Zip Code)
Ž	elth a		Charles Sachs/s	pouse	133	02 Colon	ial Road	Ocean Cit	y, MD 21	842
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Inperiment of Health and Mental Hyglene. Inperiment of Health and Mental Hyglene. Insert and Mental Hyglene. In the Marylan I it may be not set as marked other than "natural; or iteme 23 a or 28a-1 show eny injury or other treumatic event, the Marileal Examinar must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specification)	Removal from State	Db. Place of Dispo cemetery, cren	sition (Name of natory or other place	ca)	Date 20	c. Location - City or	Town, State
Balti	permit. Depertm Importa eny inju		21. Signature of Funer II Service Licer Ranald S.	The second secon	tor St	Name and Addre ate Anat altimore,	ss of Facility Omy Boar MD 212	d 655 W. E	Baltimore	Street
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the					ι,	Approximate Interval Between
	Physician	1	Immediate Cause (Final	1		acci				Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a cor		acce	0000			
	Examiner		Sequentially list conditions	h						
	ק ק	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a cor	nsequence of):					
	ecute and -trans	cam	that initiated events resulting in death) Last	c. Due to (or as a cor						
68760,	w requires thet the death certificets be executed been signed by the attending physician and should be deteched for use as the burial-transit	edical Examiner		. Due to (or as a cor	isequence or,					
687	ficeta physis the	edic		d						
X	nding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr					23d. Date of de	livery
m	death e atte	cla	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time		Ectopic pregnancy Other <i>(specify)</i>	/		Month	Day Year
P.O. Box	The law requires thet the death cer ate has been signed by the attendir paga 2 should be deteched for use	by Physician/N	9 Unknown	9∐ Unknown						
ŝ	es the	by F	Part II. Other significant conditions of	8 1	t resulting in the ur	nderlying cause giv	en in Part I.		A .	o the cause of death?
ord	sen s	ted	Darral des	hites				1 Tes	2/20No 3□P	robably 4 Unknown
Division of Vital Records,	law ras be	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u> </u>	: The	Sol						performe 1 □ Yes 2	d? death? ☑No 1 ☐ Yes	2 No
Zita Zita	ician cartifi ector	Be	25. Was case referred to medical examiner?	Hospital:		. 3□ DOA Oth	00	ath (Check only one)		
5	Phys this	. To	1 Yes 2 No 27. Manner of Dealt	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien 28b. Time of	t 3□ DOA 28c. Injur	4 🗆 140131119 F	10me 5 Residence 28d. Describe how		ocify)
5	ding h. After fune	tlon	1 Natural 5 ☐ Pending	(Month, Day Yea	ar) Injury	Wor	k? Yes 2 □No	200. Describe now	injury occurred	
/isi	Atten deat ctor: y the	flca	3 Suicide 6 □ Could not b	e 28e. Place of Injury -	At home, farm, str				et and Number or R	ural Route Number,
á	ei or s eftar i Dire	Certification:	4 Homicide	building, etc. (Sp	pecify)			City or Town,	State)	
	To the Hospitel or Attending Physician: The law within 24 bours effar death, within 24 bours effar death. To the Funeral Director: After this cardificate has completely filled in by the funeral director, page 2:	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	ysician: To the best of my niner: On the basis of exac and manner stated.	knowledge, death mination and/or inv	occurred at the tire estigation, in my o	me, date and place pinion, death occ	e, and due to the cau urred at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To th within Fo th	Me	29b. Signalure and title of certifier			29c. Licens	e number	290	I. Date signed (Mon	th, Day, Year)
,			Joch Sa	Com		1)29	8257	8	19/07	
			30. Name and address of person who		(Item 23a) (Type,	Print) (1	A		5.045
			7000 1 3.	MD 13	3111 Co	astal.	Hury,	O com C	ity MD	21842
	Sta	_	31. Date filed (Month, Day, Year) AUG 1 7	32. Régistrar's S	Signature		7			
	Registr			LILLY METERS	II M					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 10:00PM August 2007 Nina Juanita Shipley /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A <u>Union Memorial Hospital</u> Baltimore 8. Date of Birth (Month, Day, Year) 12.04.1929 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthdav) Social Security Number **Funeral** 1□M 20 F Days MD Director 220.24.4356 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD N/A Baltimre 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21211 3630 Keystone Avenue Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Mail Clerk Administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Emma Veasel Franklin G. Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 ment of Health a 4008 1/2 Roland Avenue, Baltimore, MD 21211 Thomas Shipley/son item 27 r other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Dispositión permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08.17.07 Beltsville, MD Chesapeake Crem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee eRi Alternative 8717 Green Pastures Dr. MD Approximate Interval Between Onset and Death 23a. Part1. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Severe /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical / the attending p use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available page 2 s Be P this 2 Certification: after death. Medical

Division or Vital Records, P.O. Box 68760, filled in by the funeral director, ie Hospital o 24 hours aff e Funeral D To the Hosp within 24 hor To the Fune completely fi

Baltimore, Maryland 21215-0036

							performed? 1 Yes 2 No	death? 1 □ Yes 2 □ No	
	Was case referred to medic	cal				26. Place of Dea	th (Check only one)		
	examiner? 1 ☐ Yes 2 ☐ No	Hos	pital: 1 npatient 2	ER/Outpatient	з 🗆 [OOA Other: 4 Nursing H	ome 5 Residence 6	□Other (Specify)	
	Manner of Death 1 Natural 5 Pend investigation		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred	
	3 Suicide 6 Coul 4 Homicide deter	d not be rmined	28e. Place of injury - At ho building, etc. (Specify	ome, farm, street	, facto	ory, office	28f. Location (Street and City or Town, State)	l Number or Rural Route Number,	
29	a. Certifier 1 ☐ Certify (Check only 2 ☐ Medic	ying Physici al Examiner	ian: To the best of my kno	wledge, death o	ccurre stigati	ed at the time, date and place on, in my opinion, death occu	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)	

State

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

D006317 Union Memorial

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 1 7 2 7 2007

Amend Items 29d per the of Maryland 1990 timent of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Year Physician 10:05 PM THEODORE SAMPSON 2007 JULY 01 /Medical 4a Fecility Name (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BALTIMORE FUTURECARE CHERRYWOOD EISTERS TOWN 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 6. Sex 8. Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 217.60.0396 Yrs. Director 4UGUST 09 UNKNOWA 1952 Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hygiene. Intended them 23 or 28e-1 show int: If Item 27 is marked other than "natural", or items 23s or 28e-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28e-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2√ No Director Baltimore Reisterstown 10e. Street end Number 10f. Zin Code 10g. Citizen of What Country? 12020 Reisterstown Road 21136 Funerai USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: black <u>ک</u> 3 Nidowed 4 Divorced Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Neme (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be 27 Is marked r traumatic မှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Depertment of Health a Important: If Item 27 Is any Injury or other tra Future Care Cherrywood 12020 Reisterstown Road Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donetion 5 ☑ Other (Specify) in state 21. Signature of Funeral Service Ronal d S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Dnset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical METASTATIC ESUPHAGEAL CANCER Examiner Due to (or es a consequence of) Examine the buriel-trensit Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of) i effer death.
I Director: After this certificete has been signed by ure was a fair by the funeral director, page 2 should be deteched for use as it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown HUMAN IMMUNODEFICIENCY þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy HEPATITIS C performed? 1 Tes 2 5 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient Medicai Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpetient 3□ DOA 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 XNaturel 5 Pending investigation 1 Yes 2 No M 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital or within 24 hours e To the Funaral C 12 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature July 3, 2007 D6053337 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Suite 203 Baltimore, Md Zizog Avenue 2835 and 32. Registrer's Signature State Danks Registrar

DHMH 16 Rev 6/95

07-06258 Lee Skinner Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 26522

		Registrar Certificate of	Deain	Reg.	
Physicia ledical Examin	n/	1. Decedent's Name (First, Middle,Last) Lee E. Skinner		Date of Death Month D August 14, 2	3. Time of Death 2007 1146 hrs
		Facility Name (if not institution, give street and number) Bon Secours Hospital	 b. City, Town, or Location of Death Baltimore 		4c. County of Death N/A
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	_	MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		214-50-0485 1X M 2 F 59 Yrs.	Months Days Hours Min.	AUG 18	1947 Country) MD
á	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locatic	on		10d, Inside City Limits
d how any		MD N/A Baltimore	A SUB		1 X Yes 2 No
daryland 28a-f show datonce,	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once.		2115 W. Baltimore Street	21223	- nif . Van an Na	USA 14. Race - American Indian, Black,
ath wit	Funeral	1 X Never Married 2 Married Armed Forces?	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto		White, etc.
after de al", or	by Fu	or Dates:	Yes 2 X No specify:	1-1-1-	Specify: Black
hours a	ed b	during mo	s's Usual Occupation (Give kind of ost of working life. DO NOT use ret	work done	6b. Kind of Business/Industry
036 thin 72 ne. r than " ledical	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Handy			Self Employed
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last)	18.Mother's Name Beneva	e (First, Middle, Ma Tillma	
2 2 4 2 9	To Be	Wallace Skinner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or		
Tore, MD 2 ages 1 and 2 shou nt of Health and It. If item 27 is n other traumatic	٦	Wallace Skinner - father 2240	W. Lexington Str		
ore, MEss 1 and 2 sl of Health an If item 27		1 Burial 2 Cremation 3 Removal from State crematory or oth			20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If itel injury or other tr		4 Donation 5 Other Specify: Metro Cre	matory, Inc. 8/1	6/2007	Baltimore, MD
Balt permit Depart Impor		21. Signature of Funeral Service Licensee H. Williams	remation Society 99 Frederick Roa	7 of Mary ad, Balti	land, Inc. more, MD 21228
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	ne mode of dying, such as cardiac	or respiratory arres	t, shock, or heart Approximate Interval Between Onset and
/Medical Examiner	3	Immediate Cause (Final disease a. Complications of Chronic Alcohol L	Jse		Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.			
	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
/ p is	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
executed an and all - transit		d. UNPENDED AMENDED			
8760, tificate be execut ng physician and as the burial - tra	ın/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
mg as t		past 12 months?	tal death 3 Ectopic pregr her (Specify)	ancy	Month Day Year
Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 Unknown g Unknown		One Did tob	pacco use contribute to the cause of death?
Records, P.O. Box 6 The law requires that the death cer cate has been signed by the attendi page 2 should be detached for use	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		2 ✓ No 3 Probably 4 Unknown
ords, I				24a. Was a	
Recor The law r cate has t	Completed			autops perform 1 Yes 2	ned? death?
al Re an: Th ertifica	o l	25. Was case referred to medical	26.Place of Death (Check		
of Vital Records, ing Physician: The law require After this certificate has been si uneral director, page 2 should t	To B	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 27 Manner of Death 28a, Date of Injury 28b, Time of			Residence 6 Other:
	ion:	27. Manner of Death 1 ✓ Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of	1 Yes 2 No		
Division of Vital B To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	et, factory, office building, etc.	28f. Location (Stor Town, St	treet and Number or Rural Route Number, City ate)
Divisi To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by		4 Homicide determined (Specify) 29a. Certifier A Contificing Physicians To the best of my knowledge death occul		d due to the source	(a) and manner as stated
the Ho hin 24 the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation	rred at the time, date and place, at tion, in my opinion, death occurred	at the time, date a	and place, and due to the cause(s)
To To	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		Donna nu incerti, M.D.	O.C.M.E.		August 15, 2007
ų l		Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD	1 Penn Street, Baltimore, I	MD 21201	
St	ate	Dog Charles Competition			
Regis			silv		
DHMH 17 Rev 1/2	001	OCME ORIGINA	NL.		

	•	- POI	artment of Health and Me	ental Hygien	711111 7657.1
Physicia	an	1. Decedent's Name (First, Middle, Last)			3. Time of Death 3. Time of Death 3. Time of Death
/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death RANDAUSTOWN	4	c. County of Death BALT MORE
Funeral Director		5. Social Security Number 6. Sex 122468436 125M 2 F 60 Yrs.	If Under 1 Year If Under 24 Hrs. 6	B. Date of Birth (Month, Day, Year Junuary 4,	9. Birthplace (State or Foreign Country)
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lite RAN	ocation DALLSTOWN		10d. Inside City Limits 1 ☐ Yes 2 X No
n with the	al Direc	10e. Street and Number 9802 PLOWLINE RD	10f. Zip Code 21133	10g. C	Citizen of What Country?
within 72 hours after death with the Maryland ene. then "netural", or items 23e or 28e-f show its Medical Exemiran must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 ☑ No Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: H.W.C.M. H.M.C.M.
within 72 hou ane. then "netura se Madical E	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b.	Kind of Business/Industry Con Structorn
uld be filed v Mental Hygie irked other i	To Be Co	17. Father's Name (First, Middle, Last) Calvin Tinson, Sa.	18. Mother's Name (First, Middle, Maide	en Sumame)
Pages 1 and 2 should be filed within 72 hours after death with the Marylan hent of Heelth and Mental Hygiene. nt: if Item 27 is marked other then "netural", or Items 23a or 28a-1 show yor other treumatic event, the Medical Examination must be notified at ity or other treumatic event, the Medical Examination.		20a. Method of Disposition 1 Rurial 2 Officemation 3 Demonal from State 20b. Place of Disposerer, creening and completely, creening and completely, creening and completely.	matory or other place)	te 20c.	mills mo 21244 Location - City or Town, State Suffmore, mo
permit. Pages Depertment of H Important: if ite eny injury or of once.		21. Signature of Funerial Service Licensee	2. Name and Address of Fability There Elose 5176 Belown	Fun eval	Semice, P.A. Bultimore MBZ120
Physician physician and physician and physician and physician and physician and physician physic	licai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	TC CARDIOVASCUL		Approximate Interval Between Onset and Death
es thet the death certilica igned by the attending ph be detached for use as th	by Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
The law requires thet the ste has been signed by th bage 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Noknow
	Completed			24a. Was an autopsy performed?	
Physicien: The this certificete ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death		6 □Other (Specify)
After After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury		8d. Describe how in	
i Sign	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, Sta	
the Hospital hin 24 hours e the Funeral mpletely filled	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.		d at the time, date a	
L		29b. Signature and title of certifier Mull of Mu	D43481	A	ULUST 13, 2007
J.		30. Name and address of person who completed cause of death (Item 23a) (Type MCMACU POTNICO 5101 010 31. Date filed (Month, Day, Year) 32. Registrar's Signature		AUSTON	MANYLAND 21133
Sta Registi		31. Date filed (Month, Day, Year) AUG 1 7 2007 AUG 1 7 2007	ale)		,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 16:00 B Terron Nai Shawn Thurman August 09, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 11 M 2□F Yrs. Director 08/09/07 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Md 10e. Street and Number 10g. Citizen of What Country? Funeral 38<u>15 E. Joppa Road</u> 21236 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 0 Infant Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thurman Lattrell Herger Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State AUG 14, 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility AND SONS CU. 16924 (2) ONACO OIL MUNKTON 21111 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Spontaenous delivery of nonviable 21 4/7 week male Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner due to imcompetant cervix, premature rupture of membranes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-tra or Attending Physician; The law requires that the death certificate be exec Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2√No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA P 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

or Vital Records. filled in by the funeral Division within 24 hours a

To the Funeral I To the Hospital

> State Registrar

completely

Medical

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.

2. Registrar's Signature

6701

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Aaron Magat, MD,

31. Date filed (Month, Pay, Year) AUG 1 7 2007

DHMH 17 Rev 1/2001

m

Charles St. Baltimore, MD 21204

XXcertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D39167

29c. License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

August 09, 2007

State of Maryland / Department of Health and Mental Hygiene) 26525 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** August 8, 2007 9:20 AM M Eleanor L. Woodring /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Severna Park 604 Whittier Parkway If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🛱 F Yrs. 223-30-2264 79 1928 Washington DC Director May 16, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir then "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be nutified at 1 ☐ Yes 2√2 No Anne Arundel Severna Park Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 604 Whittier Parkway 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental I permit. Peges 1 end 2 should be Department of Heelth and Mental important: if item 27 is marked any july or other traumatic events. Florence Irene Bailey Michael Anthony Vitale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 604 Whittier Parkway Severna Park, MD 21146 Joseph R. Woodring/spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑Donation 5 ☐ 10ther (Specify) 21. Signature of Funer II Service Licensee Ronald So World State Anatomy Board 655 W. Baltimore Street Director my 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Pair 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) wetastatic Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine certificate be executed burial-transit end Due to (or as a consequence of): Box 68760, Physician/Medical use as the attending I 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4☐Pregnant at time of death signed by the al d be detached fo 5 Other (specify) o 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown eral Director; After this certificate has been s filled in by the funeral director, page 2 should Completed 24a. Was an autopsy performed? 1 ☐ Yes 22 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ٩ 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation Natural 1 Yes 2 No death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide efter ō To the Hospital o within 24 hours eff To the Funeral Di completaly filled in Certifying Physician: To the best of my knowledge death occurred at the time date and blace, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 20a Cartifier Medical 29c. License number

D 4 4 959 29b. Signature and title of certifier gozs Ritchie Huy suite 134 Pasadena MD 2/122 completed cause of death (Item 23a) (Type, Print) DodgeMO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19b per fb 8870 8-23-07 vt
State of Maryland Department of Health and Mental Hygiene

amend item 19b per fb Certificate of Death

Reg. No. 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Doris Rebecca Wynn 8 12 2007 5:45p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pikesville
If Under 1 Year | If Under 24 Hrs. 4116 Balmoral Circle Baltimore 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours 1 □ M 2 🗙 F 81 12 1925 Director 231-22-1291 10 VA Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2X No Director MD Baltimore Pikesville 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 4116 Balmoral Circle 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hostess llth N/A Rite Aid Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Herbert Hobbs Cora Johnson 2 19a. Informant's Name/Relationship (Type. Print) Joyce Dawkins-daughter Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₩₩Burial 2 Cremation 3 Removal from State Poplar Lawn Baptist 8/21/2007 4 ☐ Donation 5 ☐ Other (Specify) Blackstone ٧A Church Cemetery dress of Facility 21. Signature of Funeral Service Licensee March F.H. East 21202 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by infected skin ulcers, malnutation, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No tract infections 24a. Was an autopsy performe certificate 1∐ Yes 25. Was case referred to medical examiner?

1 \(\sum \text{Yes} \) Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 1 Matural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 🔊 No na 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) "N Cambine St #7143 Balto 21287 30. Name and a W LEVER

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month August 15, 2007 Physici<u>an</u> 12:05 P.M Diana Hsui Fang Woo a.k.a. Diana T. Woo /Medical 4a Facility Name (If not institution, give street and number) Manor Care Springhouse Assisted Living 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rethesda If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) December 25, 1923 9. Birthpla Countr, China 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F 83 220-50-6610 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Bethesda Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 20817 5800 Greentree Road death \ Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examines 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Asian 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Special Education Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sheng Fung Kwong Yuey Sum Tan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5800 Greentree Rd., Bethesda, Maryland 20817 Elliott W.J. Woo / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 17 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Bethesda, Maryland Montgomery Crematorium, Inc. 21. Signature of Funeral Solvice Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00896 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Renal Failure months /Medical Due to (or as a consequence of) Examiner Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Diabetes Mellitus autopsy perform 1 Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No မ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760 s after deatn.
ral Director: After this filled in by the within 24 hours a

To the Funeral C

completely filled i

State

Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

Loreto S. Albiol, M.D., 31. Date filed (Month, Day, Year) AUG 1 7 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8218 Wisconsin Ave., #305, Bethesda, Maryland 20814 32 Registrar's Signature Carlina .

🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D31319

29d. Date signed (Month, Day, Year)

August 16, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 12:25 PM Timothy Williams 2007 August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Sinai Hospital
5. Social Security Number of Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 214-72-0126 39 Hours ₩ 2 F Months Days Yrs. Aug 29, 1967 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Wes 2 No Baltimore NIA Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code States United Completed by Funeral Heights Avenue 21207 Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 █ No Specify. Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construct ion Laborer 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ပ UNKHOWN Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Woods - Saint Bolto, MD 21207 Worker 4017 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Aug. 202007 Battinine, mo Mt Carmal Cem 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 1 Ams Funeval Savura, Rd. 21. Signature of Funeral Service Licensee alvin I. L. 1.0.BOF 11657 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): week /Medical Examiner HIVIAIDS Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last 4 years Due o (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Adrenal Insufficience Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work?

the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, as the t for use page 2 s director, this After

Baltimore,

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu death.

State Registrar

4 Homicide 29a. Certifier

1 Natural

2 Accident

3 Suicide

6 ☐ Could not be determined

5 Pending investigation

28a. Date of Injury (Month, Day Year)

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

RES-000

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

August 14, 2007

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jennifer Durphy Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year) 7 2007 39 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:00A M Viane 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) せつしょ 4017 Seabird Way Elliwitt 8 Date of Birth (Month, Day, Year) 12/31/1947 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Months Days 1 □ M 2 🕅 F 225-80-5182 59 France Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 21 No Ellicott City Howard 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 4017 Seabird Way 21042 USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No White 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant The Rouse Co. +318. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert DeVille Monique Coqui 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John C. Vranish / Son 670 Cog Ct., Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Metro Crematory 08/20/2007 Catonsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Gary L. Kaufman Funeral Home at MMP, 7250 Washington Blvd., Elkridge, MD 21075 is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Part1. Enter the disease, r comp case ck, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) C houv Due to (or as a nsequence of) Sequentially list conditions, if any, leading to immediate the sequence of the Due to (or as a consequence of) Due to (or as a consequence of) 23d. Date of delivery

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Director

Funeral

3

Completed

MD

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

traumatic event, the Medical

injury or

marked other than

permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 is marked of

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

Hospital or Attending

pe

burial-transit the as use ŕ page

Examiner Physician/Medical 3 Completed Be

funeral director,

မှ Certification:

attending physician been signed by the sahould be detached has certificate After this within 24 hours after death. To the Funeral Director: completely filled in by Medical

15

State Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

1 Yes

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certified

25. Was case referred to medical examiner?

2 No

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 5 Other (specify)

2 ER/Outpatient 3 DOA

28b. Time of

3 Ectopic pregnancy

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown

Month

24a. Was an autonsy perform 26. Place of Death (Check only one)

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

Day

Year

28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type,

31. Date filed (Month, Day, Year)

32. Registrar's Signature

•			Please	Type or Prin AMEND ITH State of M AMEND IT	nt in Blac M#5, per invlarie 7 EM#5, per	k Indelik FH C87 Jepartne FFH C87	ole Ink.	Ensur 7/07 W leath a	e All Copi Sd Mental	es Are	Legible	17 265	31
(Physic	ian	1. Decedent's Name (First, Middle, Las	")		Octune	ate or	Deatti	2. Date of Month	f Death	ay Ye		ath
	/Medi		ETHAN DANIEL 4a. Facility Name (If not institution, give	ANGELL street and number		4h Ci	ty Town o	r Location of	Doath 1		c. County of D		IVI
	Exami Funeral	ner	The Johns 5. Social Security Number G. Se	lopkins	Hospit	rthday) If Und	der 1 Year	more If Under 24	Hrs. 8. Date of	4	1 9 1	Birthplace (State or Fo	reign
	Director		216-79-2925 Usual Residence of Decedent			Yrs.		9	19 Aug	5 20	07 Ma	ryland	
	yland yow at		10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City L	ímits
	a-f st	cto	MD Caroli	ne	Pres	ton						1 □ Yes 2	ŠNo
	iff the	Director	10e. Street and Number			10f.	Zip Code		·	10g. C	Citizen of What	Country?	
	ath w s 23a nust t	ra	5710 Bethlehem				2165				S.A.		
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			cedent of H pecify Cuba 2 X No	lispanic Origii an, Mexican, Specify:	n? (Specify Yes o Puerto Rican, etc.	r No-)	14. Race - A Black, W Specify: V	_	
5-0	72 h 'natu dical	etec	15. Decedent's Ed (Specify only highest grad	cation le completed)	16a.	Decedent's U	sual Occup	ation during most o	of working	16b.	Kind of Busine	ss/Industry	
21	filed within Hygiene. other than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	(Give kind of life. DO NOT n/a	use retired	d)	g				
and	be fill tal H ed oth	Be	17. Father's Name (First, Middle, Last) Brandon K. And	r a l l a r					s Name (First, Mi		,		
Maryland	should be fand Mental H s marked ot umatic ever	ပ္	19a. Informant's Name/Relationship (7		106	Admilian Autom	(0)		san Mae				
\mathbb{Z}	and 2 sho ealth and n 27 Is ma		Brandon K. Ange						or Rural Route N				
ē,	is 1 and 2 of Health item 27 I	8	20a. Method of Disposition		20b. Place of	f Disposition (A	lame of	-	Date			or Town, State	
m o	Pages nent of B ant: If ite ary or of	١.,	1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Crum	pton (Cemet	ery 8	3/14/07	C	rumptc	n, MD.	
Baltimore,	permit. Pa Departmen Important: any injury once.		21. Sign flur Fundal Service Licen		400510	Galler 118 V	and Addre	ss of Facility neral Cross	Home of	of Si	tephen	L. Scha 21635	ech
	Physician		23a. Part1 Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused ne cause on each lin	e.	HVPaP	ode of dyir	ng, such as ca	ardiac or respirato	ry arrest,		Approximate Interval Betwee Onset and Deat	n
-	/Medical Examiner	<u>.</u>		Premate		olonge	1 10	ptore	of Maribi	AN FS		6 his	
7	oe executed cian and ourial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	5605	a consequence							6415	_
68760,	ficate be ex physician s the buria		l	/)	A TUT	Ey						6415	
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the bunal-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic 5 □ Other				-	23d. Date of Month	delivery Day Year	
σ,	w requires that the d been signed by the should be detached	by Pt	Part II. Other significant conditions co	ntributing to death bu	t not resulting in	the underlying	cause give	en in Part I.	23e. [oid tobacco	use contribute	to the cause of death	1?
ğ	equire en sig ould b	q pa	- NEUMOTHOSA	X					_ '	☐ Yes	20 No 3□	Probably 4 □Unkr	IOWII
		Completed	OS Was accordant to a dist						— l a	Vas an autopsy performed es 200 N	prior death		lable of
Š	Attending Physician: r death. ector: After this certifica by the funeral director, i	To Be	25. Was case referred to medical examiner?	lospital: Inpatier	nt 2□FB/Out	tpatient 3□ I	Othe	ar.	f Death (Check of		о Понь <i>(</i> б		
ō	ig Phys ter this neral dii		27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. T	Time of	28c. Injun Worl		ing Home 5 ☐ F 28d. Descr		ury occurred	респу)	
ioi	endin ath. or: Af he fur	atio	1 Natural 5 Pending 2 Accident investigation	(INOTILIT, Day	rear) II	njury M		(? Yes 2∐No	,				
Divis	i g f g	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju building, etc	ry - At home, far . (Specify)	rm, street, facto	ory, office		28f. Location City of	n (Street a Town, Sta	and Number or te)	Rural Route Number,	
	the Hospital in 24 hours a the Funeral ipletely filled	Medical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best oner: On the basis of and manner sta	examination and	, death occurre d/or investigati	ed at the tin on, in my o	ne, date and pinion, death	place, and due to occurred at the ti	the cause(me, date a	s) and manner nd place, and (as stated. due to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	\		2	9c. License	_		29d. D	ate signed (Mo	onth, Day, Year)	
)			1/1	7,10			063	7//		$\perp c$	17/0	6/2007	
	2		30. Name and address of person who co	GOO North	Wolfe	5+ NE	Iron.	2-133	BAIL	MON	M) Q	1287	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 7 2007	32. Registra	r's Signature	perli							

			1 - For State Registrer	State of Maryla		artment of F tificate of		F	leg. No.	26531			
	Physic	an	1. Decedent's Name (First, Middle, Last) Rose H. Blond	1or				2. Date of Dea Month August	13, 2007	3. Time of Death 1:15 P.M			
	/Medic Examir		4a. Fecility Name (If not institution, give s			4b. City, Town, o	r Location of Death		4c. County of Dea				
			Hebrew Home of			Rocky			Montgo	mery			
8	Funeral Director		0.1. 00 0000	7. Age (In y	yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March I	8, 1912 M	9. Birthplace (State or Foreign Country) 1912 Maryland			
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits			
	Mary B-f sh	tor	Maryland Montgomer	ry	Rockvil:	le				1 ☐ Yes 2 ☐ No			
	or 28	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?			
	eth w	ral	1801 E. Jefferson			208			U. S. A.				
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it is Mudical Evarither rusal be notified at ODGE.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 	1	Mas Decedent of F f Yes, specify Cuba I□ Yes 2XNo	dispanic Origin? (S an, Mexican, Puert Specify:	pecity Yes or No- o Rican, etc.)	Specify:				
21215-0036	in 72 hou	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. (Give kind of work done during most of working life. DO NOT use retired)							Kind of Business/Industry			
212	d with giane. or ther	om	Elementary/Secondary (0-12)	College (1-4or 5+) 1 Year	S	ecretary	•		U. S. Go	U. S. Government			
Maryland	I be file ntal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last) Isaac Harris				18. Mother's Nam		Maiden Sumame)				
Ž	should nd Me mark imatic	2	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	q Address (Street			r, City or Town, State,	Zip Code)			
	alth ar 127 le		Barbara P. Gorban	-		,			mac, Maryl				
Baltimore,	Pages 1 a nent of Hea nt: If item rry or othe		20a. Method of Disposition 1 XBurial 2 □Cremation 3 □R 4 □Donation 5 □Other (Specify)			sition <i>(Name of</i> natory or other plac Lebanon	8/15	Date / 2007	20c. Location - City or Adelphi, M				
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service License	Otottem		iward sag 091 Rock	gel ^F runer kville Pi	al Direc ke, Rock	tion, Inc. ville, Mar	yland 20852			
68760, 9	Physician /Medical Examiner Style prize transit is prize transit is prize prijetransit is pri	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
	The law requires that the death certifical tite has been signed by the attending phyage 2 should be delached for use as the	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 L No 9 □ Unknown	23d. Date of de Month	23d. Date of delivery Month Day Year								
	w requires that been signed by should be deta	Completed by Ph	Part II. Other significant conditions con	.	atribute to the cause of death?								
Division of Vital Records,	The law rec ite has bee bage 2 shor							24a. Was a autop: perform	sy prior to	utopsy findings available completion of cause of			
	ician: Th certilicate rector, pag	Be	25. Was case referred to medical examiner?			th (Check only or							
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	llon: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?				ome 5 Residence Residence Residence 1	ecify)				
		edical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	treet and Number or R n, State)	and Number or Rural Route Number, ate)								
	ne Hospitu n 24 hours ne Funera		29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	icien: To the best of my ler: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the tirestigation, in my o	ne, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)			
	To the within To the comp	Me	29b. Signature and title of certifier	1. 1.0	1					29d. Date signed (Month, Day, Year)			
}			Indeer feculatill Douge 716						August 1	August 13, 2007			
	10		30. Name and address of person who con	mpleted cause of death (I	tem 23a) (Type, 1	ontros	e Rd, Ro	nekville	16/208	752			
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 7 200	32 Registrar's Si	gnature do	well s	,						

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Blonder Rose

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Poepartment 87 Health 7 and Mental Hygiene 2 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) Charlotte Bollinger 2. Date of Death 3. Time of Death **Physician** 1004 PM AUGUST BAKER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hunder 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) May 26,1927 Johns HOPKINS tospital 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2√F Months 80 Director 212-24-6049 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits a or 28a-f show be notified at 28a-f shov Maryland Carroll Taneytown 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 308 Taney Heights Drive 21787 USA "natural", or items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: spWhite 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Bank Teller Banking permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygis Important: If Item 27 Is marked other any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles A. Baker Lillian Sell 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah C. Strine/daughter 308 Taney Heights Drive, Taneytown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Lutheran Cem. 08/15/2007 Taneytown, MD 21. Signature of Funeral Service Licenseg 22. Name and Address of Facility Skiles Funeral Home 136. E. Baltimore St., Taneytown, MD John M. Skiles M00534 21787 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate
Interval Between
Onset and Death
Hours Immediate Cause (Final **Physician** SCHEMIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 36 HOURS trial Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): physician at the burial Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ HYPERTENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s certificate has autopsy performe death? 1 ☐ Yes 2 ☐ No 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-000 AUGUST LOKKMAN, MD o completed cause of death (Item 23a) (Type, Print) 30. Name and ad ess of person

Registrar

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State

USTIN L

31. Date filed (Month, Day, Year)

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7 2007

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32 Registrar's Signature

MD

WOLFE STREET BALTIMORE MARTLAND ZIZET

141 State

within 24 hor To the Fune completely fi

Medical

(Check only

29b. Signature and title of certification

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

118 North

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Sui/e 38.

29d. Date signed (Month, Day, Year)

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		•	1 - For State Registrar			tificate of L				Reg. No. 2	007	26534			
f	Physicia	20	1. Decedent's Name (First, Middle, Last)				-		2. Date of De Month	ath Day	Year	3. Time of Death			
	/Medic		Doris Anette Bennett						July 3	31, 200		6:45 A. M			
Jan.	Examin	er	4a. Facility Name (If not institution, give street and number) Solomons Nursing Center			4b. Gity, Town, or Solomon:		if Death			4c. County of Death Calvert				
سائد	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday)	If Under 1 Year_	If Under 2		8. Date of Bir	th	9. Birth	place (State or Foreign			
	Director		216-24-1063 ^{1□M 2} XF	79	Yrs.	Months Days	Hours	Min.	(Month, Da	1928	Mary	land			
	and *		Usual Residence of Decedent 10a. State 10b. County 1	I0c. City, Tov	wn or Loc	ation						10d. Inside City Limits			
	Maryla f sho ied at	ō	MD Calvert Solomons									1 ∐ Yes 27 No			
	n the	Director	10e. Street and Number			10f. Zip Code				10g. Citizen o	f What Cou	ntry?			
	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	alD	13325 Dowell Road			20688			United	Stat	es				
	er dea tems ner m	Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?		13. W	las Decedent of Hi Yes, specify Cuba	ispanic Orig in, Mexican	gin? (Spe n, Puerto I	cify Yes or No Rican, etc.)	- 14. Ri	14. Race - American Indian, Black, White, etc.				
30	irs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1f Yes, Give 1	1	☐ Yes 21X No	Specify:	Spec	Specify: White							
Š	be filed within 72 hours after death with the Marylar tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted	15. Decedent's Education (Specify only highest grade completed)	168	a. Decedo	ent's Usual Occupa	ation	t of workir	20	16b. Kind of	Business/Ir	ndustry			
9500-61212	ithin 7 ne. nan "r e Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		life. D	O NOT use retired)	COT WOTHIN	<i>i</i> g	.					
	filed within 72 h Hygiene. other than "natuent, the Medica		12 17. Father's Name (First, Middle, Last)	S	ales	Clerk	18 Mothe	er's Name	(First Middle	Retai					
yland	d be feat the second of the se	To Be	Carroll Linden Clarke						Wilson	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
	should and Men s marke umatic		19a. Informant's Name/Relationship (Type. Print)						ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
, Ma	es 1 and 2 should to Health and Ment item 27 is marked rother traumatic		Doris Loffler (Daughter)			5 Rousby				<u> </u>					
Baltimore,	Pages 1 and of He		20a. Method of Disposition 1X□ Burial 2 □ Cremation 3 □ Removal from State	20b. Place cemet	of Dispos ery, crem	sition (Name of natory or other plac	e)		tate	20c. Location	•				
	permit. Pages Department of Important; If it any Injury or o		4 Donation 5 Other (Specify)	Wood1		Cemetery Name and Addres			/2007			Maryland			
g	Depa Impo any I		21. Signature of Funeral Service Licensee							Tuneral					
			P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												
	Physician		Immediate Cause (Final disease or condition	E 1	MY	ELOGE	ENU	15	LEU	KEMI	A	Onset and Death			
	/Medical		resulting in death) Due to (or as a control of the												
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χ χ	leath certificate attending phy I for use as the	Physician/Med	IF FEMALE:												
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j.	the de	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 U												
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VITa	sician; The law certificate has t irector, page 2 s	Be c	25. Was case referred to medical examiner? Haspital: Other: Other:									· · · · · · · · · · · · · · · · · · ·			
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DIVISION	ath. or: After	atio	1												
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	To th withir To th comp	Me													
}			AT mundiendy Physics. D 19427 August 1, 2007												
	5		30. Name and address of person who completed cause of dea Anwar T. Munshi, MD 110 Hos	spital	Roa	d, Suite		Pri	nce Fre	ederick	, MD	20678			
14	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 2007	Signature	H.	Aprile)								

			For State Registrar	State of N	/larylan		artmen rtificat			and M		jiene,		7	25535
1. Decedent's Name (First, Middle, Last) 2. Date of Death											3. Time of Death				
	Physic		William	Welford	В	urke						31	20	07	10:00A M
	/Medi Examii		4a. Facility Name (If not institution,				4b. City,	Town, or	Location o	July Jucation of Death			ounty of De		
			2071 McCracken	Drive			Du	ınkir	k				Calvert		
5.	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs.	last birthday)	If Under		If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day	Vear	9. 8	irthpla	ice (State or Foreign
, Air	Director		228-12-0600	1 X M 2□ F	89	Yrs.	Months	Days	nours	IVIID.	May 26	, 191	8 7	Countr 7110	ginia
	pu. >		Usual Residence of Decedent 10a. State 10b. County		100 Cit	v. Town or Lo	antine.				2.2			1.0	
	anyla show d at	7			100. 01									100	d. Inside City Limits 1 ☐ Yes 2 X No
	he M	Funeral Director	MD Calve	ert		Dunk									
	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ä	10e. Street and Number				10f. Zip				,		n of What		
		eral	2071 McCracken	Drive 12. Was Deceder	t Ever in 11	6 40	Man Dans	2075			-16 34 11		ed St		
	ter d item Iner	In In	11. Marital Status 1 □ Never Married 2 Marrie	Armed Forces	3?		If Yes, spec	cify Cuba	in, Mexican	, Puerto	cify Yes or No- Rican, etc.)	C.			
336	urs af	by	3 ☐ Widowed 4 ☐ Divorced	ed 1X Yes 2 If Yes, Give Year or Dates	194	6	1 ☐ Yes 2	2 <mark>∏</mark> No	Specify:			S	pecify:	white	
5-0036	2 hou	Completed by	15. Decedent's	s Education		16a. Dece	dent's Usua	al Occupa	ation		- 1	16b. Kind	of Busines	s/Indu	stry
	hin 7. 3. An "n Medi	ble	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)					of workii	ng		ŕ				
2121	d with	E O	12	0011090 (1 40		Mec	chanic	Sup	ervis	sor		WMAT	'A-Met	ro	
pu	al Hy l other	Be (17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle, I				
<u>la</u>	Ment Ment arked	2	William '	Thomas	Burke)			Rul	Эy		Holl	.aday		
Maryland	2 sho and l		19a. Informant's Name/Relationshi	p (Type. Print)		19b. Mailir	ng Address	(Street a	and Numbe	r or Rura	l Route Number	r, City or	own, State	, Zip C	Code)
Σ,	and salth		Hannah M. Burke	e, Spouse		2071	McCr	acke	en Dri	ive,	Dunkir	c, MI	207	754	
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 Demoval from Stat		Place of Dispo cemetery, crei	sition (Nam	ne of ther place	e)	D	ate	20c. Loca	tion - City of	or Tow	n, State
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Sp	есіfy)	້ Sc	outhern	Mem.	Gro	ins 8	3/3/	2007	Dur	kirk,	M)
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than 'any Injury or other traumatic event, the Meone.		21. Signature of Funeral Service L	icensee		22	2. Name an	d Addres	s of Facility	Rai	usch Fur	neral	Home	, I	P.A.
-	997 29		Martin	· MI		8	325 M	it. I	l armor	ny La	ane, Owi	ings,	MD	207	736
1			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that cause	ed the deatl line.	h. Do not ent	er the mode	e of dying	g, such as	cardiac o	r respiratory arr	est,		1	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition											, (Dinset and Death
	/Medical		disease or condition resulting in death) a. PULMONARY FIBROSIS YEARS Due to (or as a consequence of):										CALCS		
004	Examiner		Sequentially list conditions	b											
	D #	iner	To any, leading to immediate cause. Line Undership Cause (Disease or injury that initiated events c.												
	ecute and trans	am													
50,	oe ex	û	Due to (or as a consequence of):												
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical	'	d										 	
9 ×		Physician/Me	IF FEMALE:												
Вох	ath c	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Feta	Ideath 3	Ectopic pre					23	d. Date of d Month		ay Year
0	ne de the a hed f	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of d	eath 5□	Other (spe	ecify)					WORT	D	ay rear
9.	that the dended by the a	Ph/	Part II. Other significant condition	e contributing to death	but not roce	ulting in the su	adorbino oc	una aiua	n in Don't		ODo Did to			A - Al	
Š,	w requires the been signer should be d	b	Turk Strot organization condition	is contributing to death	but not read	anding in the di	idenying ca	iuse give	minrani.		1 ☐ Ye		_		cause of death?
Ö		Completed									, , ,	عرب در	2 No 3 Probably 4 Unknown		
3ec	e law has t e 2 s	nple									autopsy prior to con				y findings available pletion of cause of
		Ö									perform 1 Yes 2	ned? 2 No	death? 1 ☐ Ye		□No
or Vital Records,	ysician: is certifica director, p	Be	25. Was case referred to medical examiner?	Haaribal						of Death	(Check only on	e)			
or	Physical direction	ို	1 Yes 2 No	Hospital: 1 ☐ Inpa		ER/Outpatien			4 LI Nur		Home 5 Residence 6 □Other (Specify)				
n C	dlng I	ion:	1 Natural 5 □ Pending	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Under the Injury Injury 28c. Injury at Work?							8d. Describe ho	w injury o	occurred		
Division	tence eath tor:	Certification:	2 Accident investigation M 1 Yes 2 No												
Σ	or Atten after death Director; in by the	i i	3 Suicide 6 Could hit be 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f.								28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	pital purs a eral l	ပ္	29a. Certifier 1 Certifying	Physicians To the hea	t of my lengt	udoden doeth		- A Al 1*							
	the Hospital hin 24 hours of the Funeral upletely filled	edical	(Check only 2 Medical E.	Physician: To the best xaminer: On the basis	of examina	tion and/or in	vestigation,	at the tim in my op	ie, date and pinion, deat	n piace, a th occurre	and due to the ca ed at the time, d	ause(s) a ate and p	nd manner i lace, and d	as stat ue to t	ed. he cause(s)
	To the Hospital or At within 24 hours after of To the Funeral Direc completely filled in by	Mec	29b. Signature and title of certifier	and manner s	nateu.		29c	. License	number		20	9d. Date	signed /Mo	nth D	av Yearl
	⊢ ≯ F ŏ		Petro D	200			29c. License number					29d. Date signed (Month, Day, 7/5//07 Frederick, MD 20			
		-	20 Demonstration		dooth /!-	00a) (T	Defast)	774				. 1 3	10+		
17)+1		38. Name and address of person w	14 1.	ueath (Item	. /	LITTING TO	200	J ro	2,00	Fall	a. A	· MY	1	N-18
10	Sta	te	31. Date filed (Month, Day, Year)	WEKI, MD 32. Regis	tras Signa	ture	jai	UZ	(A) 1 F	MUCE	- 1 lear	MICK	(411)	de	2010
	Registr		AUG	2 2007	Benez 4	J. K.	dos	the B							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Da **Physician** рм 29, Berthe Manyo Banemeck July 2007 1:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 ₩ F Director 213-39-6195 Oct. 13, 1963 Gabon Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18609 Pier Point Place 20886 Funeral Gabon 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. item 27 is marked other than "natural", or Iten other traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Never Married 2 ☐ Married **Black** Manyo Berthe Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **Hospitality** Housekeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emmanuel Manyo Annemarie Banack 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i Andre Paul Ngoma/ Son 18609 Pier Point Place, Montgomery Village, MD 20886 ace of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of I Important: If ite any injury or of once. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State August 11, 2007 All Souls Cemetery Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. · Ken Stil 500 University Blvd, W, Silver Spring, MD 20901 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute thmia dysrhy disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Imonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine executed in ec 4101 anding physician and use as the burlal-tran resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) ed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be o 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate 1□ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient Certification: To this funeral 27. Manner of Death Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation (Month, Day Year) death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760. Division or Vital Records,

within 24 hours a

Hospital

State

filled in by

completely

Medical

29b. Signature and title of certifier

determined

4 ☐ Homicide

(Check only one)

29a. Certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ress of person o complete ause of death (Item 23a) (Type, Print)

Medical Cender Drive, Rockville, Md. 20850 9901 5 noun

31. Date filed (Month, Cay, Year) AUG 0 6 2007 32. Raistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2309 M ANNA E. BASSETT 02 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Peninsula Regional medical Cente WICONICO 8. Date of Birth (Month, Day, Yea 8-16-1929 9. Birthplace (State or Foreign **Funeral** Year) 1 □ M 2 🗓 F Months Days Hours 516-28-6760 77 PENNSYLVANIA Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No DAGSBORO Director DELAWARE SUSSEX 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If trem 27 is marked other than "nature." any Injury or other traumatic process. 19939 34969 GERNERAL STORE LANE US Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. ☐ Yes 2 X No FYes, Give 'ear or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No WHITE Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARGARET SURGEONER WILLIAM A. PHILLIPS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELODY HUDSON/ DAUGHTER 34969 GERNERAL STORE LANE, DAGSBORO, DE. 19939 20b. Place of Disposition (Name of PHILLIPS FAMILY Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cromation 3 Removal from State 5 her (Specify) CEMETERY 8-6-2007 CAMPBELLTOWN, MARYLAND 22. Name and Address of Facility
MELSON FUNERAL SERVICES LTD
43 THATCHER STREET, FRANKFORD, DELAWARE. 19945 21. Signature e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset, and Death 23a. Part1. Enter the disea shock, or heart failur Immediate Cause (Final disease or condition resulting in death) **Physician** Kneumonia de /Medical Due to (or as a consequence of): Examiner OPD exacela Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Dung luing and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Vnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 28b Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

BALO

Tom Swierkosz 31. Date filed (Month, Day, Year)

29b. Signature and title of c

100 E. Carroll St. Salisbury

29c. License number D58689

29d. Date signed (Month, Day, Year)

8-03-0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 0 6 2007

State

Registrar

			1 - State Of IVIA State Registrar		ertificate of I			ene 20	07 26538
	Physici	an	1. Decedent's Name (First, Middle, Last) GLENNA GAY BROCK				2. Date of Death Month		3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	July 28	4c. County of	7:45 p M
	LAGITITI		7810 Clark Road, A-43		Jessup			l .	Arundel
	Funeral Director	0	235-64-6147 ^{1□M 2} ♥F	(In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08-01-19	(ear) 040 V	B. Birthplace (State or Foreign Country) Vest Virginia
	ryland how at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	ne Ma 8a-f s	Scto	Maryland Anne Arundel	Jessup					1 XYes 2 No
	with ti	ij	10e. Street and Number 7810 Clark Road, A-43		10f. Zip Code 20794		109	g. Citizen of Wh	at Country?
	death ms 23	Funeral Director	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race	- American Indian,
2-003p	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Married 3 ☐ Widowed 4 Married 3 ☐ Widowed 4 Married 4 Married 4 Married 5 ☐ Yes, Give 7 ← Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:	Hican, etc.)	Specify:	White, etc. White
0	72 ho 'natur dical	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deci	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of work	ing I	6b. Kind of Busi	ness/Industry
7 7	l within liene. r than '	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Cash		1)		Giant Fo	oods
	be filed Ital Hyg Id other	Be	17. Father's Name (First, Middle, Last) Reed A. Maynard	'			e (First, Middle, M.		
7	should nd Mer marke matic	욘	19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ling Address (Street				tate. Zin Code)
<u>8</u>	alth ar 27 Is er trau		Glenda Gordon - Daughter	ı	4 Leaside				
ore,	of He		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Disp cemetery, cre	oosition (Name of ematory or other place	ce)	Date 2	Oc. Location - C	ity or Town, State
pairimor	t. Pag rtment rtant: njury o	4	4 □ Domation 5 □ Other (Specify)		oln Cemeter		2007 B		d, Maryland
0	permit Depar Impor any in	0	21. Signature of Funeral Service Licensee		22. Name and Addres Gasch¹s Fu	-	me, P.A.		Baltimore Ave. ville, MD 20781
١,			23. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line	he death. Do not er	nter the mode of dyin	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
,	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	consequence of):	ial in	forcti	on		Ihour
	Examiner		TVA	e 2	diabe	efes			10 vears
	ed sit	niner	Secure flat y list numbling if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):	5 1/0				10 400
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מ א מ	certific nding p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome p					23d. Date	of delivery
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		☐Ectopic pregnancy ☐ Other (specify)			Mont	,
L , C	iires that signed b d be deta	by	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause give	en in Part I.		acco use contrib	oute to the cause of death?
necoras,	w requ	letec	Devicestion		_		24a. Was an		ere autopsy findings available
ב ב	The la ate has page 2	Completed					autopsy perform 1∐ Yes 2	ed? pri	or to completion of cause of ath? ∐Yes 2 X No
VII	certific rector,	Be	25. Was case referred to medical examiner?		ont 3CLDOA Othe		h (Check only one		
5	J Phys er this eral dii	. To	27. Manner of Death 28a. Date of Injury		SIL SUDOA	4 LI Nursing Ho	me 5 Resider 28d. Describe hov		
VISIOII OI	ending ath. or: Afte he fun	atio	1 Natural 5 Pending (Month, Day investigation (Month, Day	Year) Injury		Yes 2 □ No			
2	al or Aft s after de al Directo ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injur building, etc.	y - At home, farm, s (Specify)	treet, factory, office		28f. Location (Stre City or Town,	eet and Number State)	or Rural Route Number,
	e Hospit 24 hour e Funera etely filla	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state.	examination and/or i					
	To th within To th compl	Me	29b. Signature and title of certifier		29c. License	e number		_	(Month, Day, Year)
)			Fairl WU		= D+3	237		uly 3	1,2007
2	(10)		30. Name and address of person who completed cause of de 14201 Laurel PK, Dr. #	102 La	unrel, M	P 2070	7/ Pai	11 Arn	1,2007 nstrong, m.O.
	Sta		31. Date filed (Month, Day, Year) 32. Registral	's Signature	U				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc 9871 9-7-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 12 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 August 11, Marian Elizabeth Cook 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1□M 2 1 F 1928 Maryland Yrs. 10, 220-20-4039 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☐ No Maryland Harford Havre de Grace 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 40 Robin Hood Road Box 708 21078 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Bookkeeper 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Margaret Flowers Joseph J. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21078 40 Robin Hood Rd. Box 708, Havre de Grace, Charles R. Cook (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley 8/16/07 Timonium, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Maryland 21001-3399 Aberdeen, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Socurately list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ H 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 npatient 1 🗆 Y96 2 ER/Outpatient 3 DOA 27. Mapher of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Physician /Medical Examiner efter death.
I Director: After this certificate hes been signed by the ettending pryveren end in the funeral director, page 2 should be detached for use as the burial-transit of in by the funeral director, page 2 should be detached for use as the burial-transit. of Vital Records, Division tilled in by 5 within 24 hours e To the Funeral C completely tilled

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31. Date filed (Month

other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

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State Registrar

29c. License number

Mary

29d. Date signed (Month, Day, Year)

and manner stated.

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Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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36	72 hours after death with the Maryland natural', or items 23a or 28a-1 show diest Eve circumste modified at	by Funeral Director	2267 WESTWOO	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	206 13. Was Decedent of H If Yes, specify Cuba			U.S.A. 14. Race - Amer Black, White Specify: WI	
121215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event; If a Madical Event of the right of a DDCs.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2 11 17. Father's Name (First, Middle, Last)	ation 16a	a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	during most of working d)	o O	WN HOME	ndustry
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	A Sta	to.	30. Name and address of person who core of the control of the cont	npleted cause of death (Item 23a) Mars Hall Registrar's Signature	(Type, Print)		,		
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				ERIC F. CIGANEK, M.D	., 629 RAILRO	AD AVENUE	E, CENTRI	EVILLE, M	ID 21617		
			_			And .					

State of Mary and PSepatifice 871 Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ROSE CARTER JULY Day 25 2007 6:15 ΡМ /Medical 4a. Facility Name (If not institution, give street and number)
FREDERICK MEMORIAL HOS 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/9/19/21 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 F Director 215-16 اعا3عا Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 THES 2 No Director rederick 10g. Citizen of What Country? 10e. Street and Number ns 23a or 2 must be n 30 Nort 701 Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. Int; If item 27 is marked other than "natural", or items 23: Funeral "natural", or items idical Examiner m 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced Black item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Child Care Nurse 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 10 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12801 Pinnacle Dr. 203 Germantown MD 20874 aveer Jove 11/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or c 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Cembri 7-28-07 Alexandria, VA
22. Name and Address of Ficility Greene Funeral Itoms Greene Funeral Home 21. Signature of Funeral Service Licensee Palser E 814 Franklin Street, Alexandria VA 22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sushock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ocai Physician disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by I I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 6 Other (Specify) 2 No Medical Certification: To 1 ☐ Yes 2 TER/Outpatient 3 X DOA After this 27. Manne of Death 1 ✓ atural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 Medical E 29b. Signature a 29c. License number nd title of certifier 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print) MD. filed (Month, Day, Year, 2 2007 32. Registrar's Sign State AUG 02 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			, FUI	epartment of Health and M Certificate of Death		ene 1. No. 2 0 0 7 - 2 5 5	I. O
3			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of D	eath
	Physici /Medic		JAMES HOWARD CURRIE		July 3	Day 2007 6:30	a ^M
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number) Home HCR Manor Care Hyattsville Nursing 5. Social Security Number $104-14-6543$ 6. Sex 7. Age (In yrs. last birth Nursing Number Nursing Number Numb	4b. City, Town, or Location of Death Hyattsville If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)		Foreign
	D		Usual Residence of Decedent		02-01-1		
	tarytar show	ō	10a. State 10b. County 10c. City, Town MD Prince George's Hya	or Location Lttsville		10d. Inside City 1X Yes 2	
	the N 28a-f notifie	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?	
	h with 23a or st be	al Di	4225 Madison Street	20781		USA	
215-0036	4 within 72 hours after death with the Maryland jiene. 1 than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No 1942 − If Yes, Give Year or Dates: 1945	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
5-0		etec	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	ing 16	6b. Kind of Business/Industry	
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	i Hygi Other ent, tl	Be Cc	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	aiden Surname)	
<u>Jar</u>	should be filed ind Mental Hygi s marked other umatic event, t	10 B	Donald A. Currie	Maude A	A. DeSilv	a	
Maryland				Mailing Address (Street and Number or Run 5 Madison Street, Hy			
	s 1 and 2 of Health a item 27 is other trau	Ц	20a. Method of Disposition 20b. Place of	Disposition (Name of		e, MD 20781 Oc. Location - City or Town, State	
	Pages nent of int: If its		1 N Burial 2 □ Cremation 3 □ Removal from State cemetery	, crematory or other place)		ashington, DC	
a ∃	permit. Page Department (Important: If any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	72007	4739 Baltimore A	
n	a iii e	4	Thichelle C. Charle MO1491	Gasch's Funeral Hom		Hyattsville, MD 20	
	Physician /Medical		resulting in death)	MONEARY ARLEST	or respiratory arres	st, Approximate Interval Setwe Onset and De	een eath
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ide		ner	Sequentially list conditions, if any, leading to immediate cause. Finer Indexiving):			
	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. BACTERIAL Due to (or as a consequence of	PreEUMORELA			
8/60,	be exician a	a E	Due to (or as a consequence of):			
200	ificate g phys	edical	d				
O. Box	the death certificate be executed y the attending physician and iched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Ye	ar
7	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of dea	ath?
cords,	requires that een signed b nould be deta				1 □ Yes	2⊠No 3□Probably 4□Un	known
He-	The larate has	Completed			24a. Was an autopsy performe 1 Yes 2	24b. Were autopsy findings av prior to completion of cau death? 1 ☐ Yes 2 ☐ No	railable ise of
VII	Physician: this certific	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outp	Othor	h (Check only one)	ce 6 □Other (Specify)	
_	₽ • •	⊢ ⊹	27. Manner of Death 28a. Date of Injury 28b. Ti		28d. Describe how		
DIVISION	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Sertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farr building, etc. (Specify)	n, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Numbe State)	9r,
	he Hospitt n 24 hours he Funera pletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, /or investigation, in my opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as stated. ee and place, and due to the cause(s)	
	Within Com.	Ž	29b. Signature and title of certifier	29c. License number	290	1. Date signed (Month, Day, Year)	
			- Appliate we	D40327	-	ML () (& U) †	
12	(6)		30. Name and a dre's of person who completed cause of death (Item 23a) (T VICTOR ONE LAA 732-SA HA 31. Date filed (Month, Day, Year) AUG 0 3 2007 AUG 0 3 2007	ype, Print) PARKWAY	GREENE	BELT MARYLAND 2	10770
	Sta Registr		AUG 0 3 2007 See Negistra's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 25 per dr., g871,09/194/07 albeath 1. Decedent's Name (First, Middle, Last) 2. Date of Death William Thomas Collins, Jr. **Physician** Day 2007 Year August 2, 5:35 рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Olney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. (Month, Day, Year) May 27, 1925 5. Social Securify Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⅓**M 2□F 82 577 22 3539 Director Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Examiner must Funeral 22 Dutchess Court 20832 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mayes 2 No
If Yes, Give
Year or Dates 1943 – 45 1 ☐ Never Married 2 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Comptroller Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Thomas Collins, Sr. Louise Joanna Stump ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michiko M. Collins/Wife 22 Dutchess Court, Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Gate of Heaven Cemetery August 6,2007 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licensee A Ken Shle 500 University Boulevard West, Silver Spring, MD 20901 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 years /Medical Due to (or as a consequence of): Examiner oronal if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical the attending pl for use as t IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 N Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident completely filled in by the within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

Q

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) AUG 0 6

29b. Signature and title of certifier

32. Reatrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ci

18109

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien® 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Carroll Woodrow Draper Aug /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fahrney - Keedy Nursing Home Boonsboro Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Year) 1X M 2 □ F 217-10-9198 88 Yrs. March 14, Director 1919 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-f show other treumatic event, the Micdical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Washington Smi thsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12049 Mapleville Rd. P.O. Box 151 21783 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3X Widowed 4 □ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 72 h end Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) **Assembly** Aircraft 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edgar C. Draper Beulah E. Harne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ellmportent: if item 27 is any injury or other treuonce. Linda C. Graybill (Daughter) P.O. Box 114 Cavetown, Maryland 21720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State st 16, 2007 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State August 14 ☐Donation 5 ☐ Other (Specify) Ringgold Cemetery Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 LINIS lee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death buell (or as a consequence of): **Physician** /Medical Examiner Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ettending physicien and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2 No 2 X No 1 🗌 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Inpatient 7 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerei I 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 052323 27 E 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, mol. 21740 Registrar's Signature State

Registrar

Draper, Corroll

P.O. Box 68760.

Division of Vital Records.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

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				10,G870, 8/17	/07 T	Γ $C\epsilon$	ertificate of	Death		Reg. No	200	20040
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/Media	cal			e street and number)		unici	4b. City, Town, o	ar Logotion of	July 26	$\overline{}$	• 2007 County of Dea	
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shou and M s mar		19a. Informant's Na	ame/Relationship (Type. Print)		19b. Mai	ling Address (Street	and Number	or Rural Route Numb	ber, City o	or Town, State,	Zip Code)
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	1-11			- 1	3401 Blade		Fort Line		Funeral twood,	
		23a. Part1. Enter t	he d ease, or com	plications that caused	the death						twood,	Approximate
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sician: The law certificate has b irector, page 2 s	Com								perf 1∐ Yes	ormed? 2 No	death?	,
Physician: this certific al director,	Be	25. Was case refer examiner?	r	Hospital:			ort 3G DOA Oth		of Death (Check only	one)		
Phys r this rral dii	- To	1 ☐ Yes 2 ☐ 27. Manner of Deat		1 ☐ Inpatie		ER/Outpation 28b. Time	aur 3 DOA	4 K I Nur	sing Home 5 ☐ Res 28d. Describe			ecify)
nding I th. : After e funer	tion	1 XNatural 2 ☐ Accident	5 Pending investigation	(Month, Day	y Year)	Injury	Wor	rk? Yes 2 ∐ N			.,	
· Atter	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of inju			treet, factory, office		28f. Location City or To			ural Route Number,
ital or rs afte ral Di	Cert											
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director; to	Medical	29a. Certifier (Check only one)	1 ☑ Certifying Ph 2 ☐ Medical Exar	niner: On the basis of	f examina	wledge, dea tion and/or	ath occurred at the ti investigation, in my o	me, date and opinion, deat	place, and due to the n occurred at the time	e cause(s , date an) and manner a d place, and du	s stated. e to the cause(s)
o the	Med	A	title of certifier \(\lambda\)	and manner sta	ated.		29c. Licens	se number	1 0	29d. Da	te signed (Mon	th, Day, Year)
- 3 - 5		b h	mast	ANIMS	-1	1		06	419		7-20	-07
(5)		30. Name and addr	ess of person who	ompleted cause of d	eath (Item	23a) (Type	Print)		11/		, ,	-/-
	in V		Jarboe	M.D. 240	35 3	Notch	n Road, Ho	ollywo	od, MD 20	636		
Sta Registr		31. Date fed (Mon	th, Day, Year) V	32. Registra	ar's Signa	ell	•					
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	•	1 - For State Registrar	State of Maryla			ate of l			2111	7 26547
		Decedent's Name (First, Middle, Last)				210 01 1	Douth	2. Date of Death	g. No.	3. Time of Death
Physicia /Medic		Marion Louise Dick	kerson					Month	29, 200	
Examine		4a. Facility Name (If not institution, give s	treet and number)		4b. Ci	ty, Town, or	Location of Death	0019	4c. County of De	
		SALISBURY REHAB	& NURSING		16.1.		BURY, MD			OMICO
Funeral Director		5. Social Security Number 6. Sex 216–16–7604	M 287F	s. last birthday) Yrs.	Month	der 1 Year Is Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
		Usual Residence of Decedent	84					July 20,	1923	MD
larylan ehow	_	10a. State 10b. County		City, Town or Lo	cation					10d. Inside City Limits
the Maryle 28s-f shor	ecto	MD Wicomico		yaskin	1.54					1X Yes 2 □ No
	Funeral Director	21491 Nanticoke Rd.			10f. i	Zip Code	_	10	g. Citizen of What	Country?
death death	nera		2. Was Decedent Ever in	U.S. 13. V	Vas De	2186 bedent of Hi	ispanic Origin? (S n, Mexican, Puert	pecify Yes or No-	USA 14. Race - Ar	merican Indian,
after after	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 █️No If Yes, Give	1		pecify Cuba 2 X No	n, Mexican, Puerti Specify:	o Rican, etc.)	Black, W	
CKEICSON 15-0036 n 72 hours after death will "neturel; or fleme 23a cudical Examinatorius to	d by	3℃ Widowed 4 □ Divorced	Year or Dates:							
1215-0036 within 72 hours after and then "netural; or its then "netural; or its a wedical Examina	Be Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Deced (Give	lent's U: kind of 1 DO NOT	sual Occupa work done d use retired	ation during most of wor	king	6b. Kind of Busine:	ss/industry
212	Ē	Elementary/Secondary (0-12)	College (1-4or 5+)			omest:			various	families
nd be file d othy	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nan	ne (First, Middle, M	aiden Sumame)	
larylar P should be and Menta aumatic ev	- 1	Fred Handy					Mary Do			
Maryls Maryls and 2 should alth and Mer 127 le marke or traumatic		19a. Informant's Name/Relationship (Typ						ral Route Number,		e, Zip Code)
nore, loges 1 am tof Healt or other	1	Thomas L. Dickersor 20a. Method of Disposition	20b.	Place of Dispos	sition (A	iame of		n, VA 233	95 0c. Location - City	or Town State
Pages ent of your of		1 ⊠Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State F1	cemetery, cren ceedman Church	satory o	ethod:	ist			
Baltimore, Maryland permit. Pages 1 and 2 should be fit Department of Health and Mental hy Important: If I tem 27 1e marked oth any injury or other traumatic event one.	-	21. Signature of Furieral Service License	9	22	. Name	and Addres	s of Facility		Iyaskin,	MD
<u> </u>		1		116	118	West I	Road, Sa	neral Hom Lisbury,	VID 21801	
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	eations that caused the dea	ath. Do not ente	or the m	ode of dying	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between
Physician	Ī	Immediate Cause (Final disease or condition resulting in death)	Lung	Con	-0	-1.			_	Onset and Death
/Medical Examiner		Toolking in south)	Due to (or as a conse	equence of):				10		
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):	1-	w	ne	a Paro	may	no year
cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
760, te be executed ysician and be burial-transit	Ä	resulting in death) Last	Due to (or as a conse	quence of);						
2 2 2	dicai	d.								
Records, P.O. Box 68760, The law requires that the death certificate be extended to the beath certificate be extended by the attending physician page 2 should be detached for use as the burfactory.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23	ic. If yes, outcome of pregr	nancv					001.0	
Box death cert eath cert e attendin d for use		in the past 12 months?	1 Live birth 2 Fet	al déath 3 🗌		pregnancy specify)			23d. Date of d Month	Day Year
, P.O. I that the de lead by the a detached f	nys.	9 Unknown	9□ Unknown			. ,,				
S, les tha	ል	Part II. Other significant conditions cont	ributing to death but not re	sulting in the un	derlying	cause give	n in Part I.	23e. Did toba		to the cause of death?
Cord w require been si	Сощрієте							1 - Yes	2 No 3 1	Probably 4 □Unknown
The law The law page 2 s	ğ.							24a. Was an autopsy	24b. Were prior to	autopsy findings available o completion of cause of
Vital Ficien: The certificate		25.111						performe 1 Yes 2		? es 2□ No
of Vital Physician: This cardifice	10 26	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Ho	ospital:	TER/Outestant		Othe		h Check only one		
ig Physical controls in the restriction of the rest		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	3 🗆 (28c. Injury Work		ome 5 Residen 28d. Describe how		Decity)
VISION Attending r death. ector: After y the fune	atio	1 ☐ Watural 5 ☐ Pending 2 ☐ Accident investigation	(WORLE, Day Fear)	Injury	М		r res 2 □ No			
Division of Vital Records, or Attanding Physician: The law requires I after death. Director: After this certificate has been signs in by the tuneral director, page 2 should be activitied.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, stre ify)	et, facto	ory, office		28f. Location (Stre City or Town,	et and Number or i State)	Rural Route Number,
pltal purs a cours a c		29a. Certifier 1 Certifying Physi	sian: To the heat of mules	outedes death		1 - 1 - 1 - 1 - 1				
Division of To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Director.	edical	(Check only 2 Medical Examine one)	cian: To the best of my kn er. On the basis of examin and manner stated.	ation and/or inv	estigation	on, in my op	e, date and place, inion, death occur	and due to the cau red at the time, dat	se(s) and manner e and place, and de	as stated. ue to the cause(s)
To th within To th comp		29b. Signature and title of certifier	1		2	9c. License	number	290	I. Date signed (Mo	nth, Day, Year)
		17/11/1	1-00		1	07	2974	94 1	7/70/2	7
2111		30. Name and address of person who com					1 1	/	16	/
3,00		WILLIAM ROBINS, M					KX, MD.	21804		
State Registrai		31. Date filed (Month, Day, Year) AUG 0 3 200	7 32 Registrar's Sign	I A	este	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 William 28 2:25 p M R Julv Deville 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) **™** M 2 F Months 217-60-6228 54 05/20/1953 Washington DC Usual Residence of Decedent 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7513 Deville Court 20772 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: Specify:Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Deville Marshall James A Louise Alice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 3 6 0 8 19a. Informant's Name/Relationship (Type. Print) James D. Deville/ Brother 512 Ashton Green Blvd. Newport News, Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 8/4/07 Clinton, Maryland 21. Signature of Foreral Fryice Licen 22. Name and Address of Facility Adams Funeral Home PA 191 20605 Aquasco Rd. Aquasco, Maryland 20608 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Heratocellu Due to (or as a consequence of) Sequentially list conditions, if any leading to influence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dive to for as a consequence of Due to (or as a consequence of) FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown art <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 Natural Injury

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

with the Maryland

72 hours after death

filed within 7 Hygiene.

permit. Pages 1 and 2 should be filed a Department of Heath and Mental Hygie Important: If item 27 is marked other I any Injury or other traumatic event, th

Saltimore, Maryland 21215-0036

and burial-trar physician the as use for ed by the a detached f signed to been si page 2 s certificate

P.O. Box 68760,

Records,

death certificate be executed this funeral After t

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Medical

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2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

Examiner

Division or Vital Physician: Hospital or Attending 24 hours after death. Property Director: A To the

State Registrar

29b. Signature and title of certifier

6 Could not be determined

29c. License number

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Loc tion (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Surratt 50 clinton.

31. Date filed (Month Year) 0 MD 20735, Suresh A Padelimo

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Physician /Medical **Examiner** Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed certificate has b irector, page 2 s the Hospital or Attending Physician: director, To the Hospital o within 24 hours aft To the Funeral Di completely filled in

	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	23d. Date of delivery Month Day
Part II. Other significant conditions Right Femoral	contributing to death but not resulting in the underlying cause given in Part I. Neck Fracture	23e. Did tobacco use contribute to the caus 1 ☐ Yes 2 ☒ No 3 ☐ Probably
		24a. Was an autopsy performed? 1□ Yes 2⊠ No 1□ Yes 2□ No
25. Was case referred to medical examiner?	26. Place of De	ath Check onl one)
1 X Yes 2 No	Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 □ Natural 5 □ Pending 2 ☒ Accident investigation	28a. Date of Injury 28b. Time of Injury Aug 7, 2007 1230p M 28c. Injury at Work? $1230p$ M $1 \square \text{Yes} 2 \cancel{x} \text{No}$	28d. Describe how injury occurred Fell while walking dog

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

At Home 281. Location (Street and Number or Rural Route Number City or Town, State) > West 13th St Frederick, Maryland 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D37197 August 14, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alan H. Rohrer, M.D., D.M.E., 15 West 7th Street, Frederick, Maryland 21701-4501

State Registrar

12

Certification:

Medical

3 ☐ Suicide

4 ☐ Homicide

6 Could not be

31. Date filed (Month, Day, Year)

 Registrar's Signature AUG 1 7 2007

		For State	State of		d / Depa		of Hea	alth and	Mental Hy	giene	0.07	26550
		Registrar	(not)			incate	UI DO	aur	2. Date of D	Reg. No.		3. Time of Death
Physici /Medic		1. Decedent's Name (First, Middle, I John Ogborn E							August	Day	200 ^{Year}	9:30a M
Examin		4a. Facility Name (If not institution, g	give street and nun	nber)		4b. City, To	wn, or Loc	cation of Dea	th	1	unty of Death	
		Chase Amtrack S	Station				nase				Ltimore	
Funeral Director		012-24-4962	.Sex 12XM 2□F	7. Age (In yrs. 1	last birthday) Yrs.	If Under 1 Months D		Under 24 Hrs tours Min		1930	Cou	place (State or Foreign htty) York
D .		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation						10d. Inside City Limits
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8a-f	octo	Virginia Arlin	ngton		Arlir					10a Citizer	of What Cou	ntn/2
vith ti	Director	10e. Street and Number	•			10f. Zip Ci						,
23a	Funeral	6247 Lee Hig		deat Francis III	C 42	l l	22205		Specify Ves or N		JSA Race - Ameri	can Indian
er de	nu	11. Marital Status	Armed Fo		.5.	If Yes, specify	Cuban, N	Mexican, Pue	Specify Yes or N rto Rican, etc.)		Black, White,	
rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes If Yes, Giv Year or Da	e XIII		1 ☐ Yes 2	No S	Specify:		Sp	ecify: Wh	nite
within 72 hours after death with the Maryland ene. then "naturel", or iteme 23a or 28a-f ehow he Mayloul Exeminer must be notified at		15. Decedent's			16a. Dece	dent's Usual (Occupation	n		16b. Kind	of Business/Ir	ndustry
in 72	piet	(Specify only highest		405.51)	(Give	kind of work DO NOT use	done durir retired)	ng most of wo	orking			
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should be nd Mental i marked o	To B	Carlton Case E	llis					Hilda	Ogborn			
ie, was yearled 2.12.10.000	-	19a. Informant's Name/Relationship	o (Type, Print)		19b. Maili	ng Address (S	Street and	Number or F	Rural Route Num	ber, City or To	own, State, Zi	o Code)
and 2 eaith a m 27 is		Amanda R. Ellis	(wife)		6247	7 Lee F	lighw	ay, Ar	lington	, VA 2	2205	
permit. Peges 1 an Department of Heal Importent: if Item 2 any injury or other		20a. Method of Disposition		1 0	Place of Disponentery, cre	osition (Name matory or other	of er place)		Date	20c. Local	ion - City or T	own, State
Peges nent of I		1 ☐ Burial 2 ☑ Qremation 3 4 ☐ Donation 5 ☐ Other (Spe	B ∐Hemoval from ∞ cify)	State		cis & C		nv 8/1	1/07	West (Chester	, PA
mit. Sorte		21. Signature of Funeral Service	censee	10	2	2 Name and	Address o	of Facility				
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		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that c	aused the deat	h. Do not en	ter the mode	of dying, s	such as cardi	ac or respiratory	arrest,		Approximate Interval Between
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/Medical		disease or condition resulting in death)	a. Due to	or as a conseq	uence of):	uc c	un	wyw	rever	wie	ave	
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DIVISION OF VICES INC. DOA OF THE HOSPITES THE LIPE OF THE HOSPITES THE LIPE OF THE LIPE O	ed by	4 / -	ne	eath Dut not res	Solding at the t		uso giveiri]Yes 2□I		
s bees shown	Completed								24a. Wa	is an		opsy findings available ompletion of cause of
The life ha	E								per 1 Yes	formed?	death? 1 ☐ Yes	2 X No
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Atte	1	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Place	of Injury - At h	ome, farm, si	reet, factory,	office			(Street and I	Vumber or Ru	ral Route Number,
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To the Hospitel or Attending Physicien: The law within 24 hours elter death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edicai (29a. Certifier 1 Certifying (Check only one)	Physician: To the band man	best of my knowasis of examination	owledge, dea ation and/or i	th occurred an	t the time, in my opin	date and pla ion, death oc	ce, and due to th curred at the time	e cause(s) ar e, date and p	nd manner as ace, and due	stated. to the cause(s)
thin S	Med	29b. Signature and title of certifier	and man			29c.	License n	number		29d. Date	signed (Monti	, Day, Year)
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Registrar DHMH 17 Rev 1/2001

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State

Dr. James Dickey

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ST.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cuppins

2007

NORTH

31. Date filed (Month, Day, Year)

D0036231

BACTIMORE

James Dickey, M.D.

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AULUIT 2,

21204

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Month **Physician** LUCILLE EBERLE 2007 August 4:15 /Medical a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15100 Interlachen Drive, #206 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-11-17 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 🗓 F 89 470-05-3845 Director Minnesota Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits Director Maryland 1XYes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or 2 the Medical Examiner must be n 15100 Interlachen Drive, #206 USA 20906 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe Louis Lavalley Katherine Goodnature ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau Vickie Hulcher - Social Worker 19209 Aria Court, Brookeville, Maryland 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery : 08/06/2007 Brentwood, Maryland re of Funeral Service Lit 22. Name and Address of Facility 4739 Baltimore Avenue any Gasch's Funeral Home, P.A. Hyattsville, MD 20781 M01491 richelle ho Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician apa my throng /Medical Due to (or a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🌠 No Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) ed by the a detached t 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy perform certificate 1∐ Yes 2 X No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA this 1 Inpatient Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending After (Month, Day 1 X Natural 5 ☐ Pending investigation ours after death.
neral Director: A
filled in by the fu М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) 05342 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18109 PRINCE DF-1 ward 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State AUG 0 3 2007 Registrar

Physici		Decedent's Name (First, Middle	e, Last)					2. Date of D		V	3. Time of Dea
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Funeral Director		192-32-9162	1□ M 2⊠ F		65 Yrs.	Months Days		In. 8. Date of Bi (Month, D	ay, Year)	Co	PA
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shov	ō	10a. State 10b. County Wa	ashington		0c. City, Town or	Cascade	⊇				1 ☐ Yes 2
286-	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Co	untry?
3a or	iO le	14323 High	ock RD.,	PO E	3ox 148	217	719			USA	
ems	ner	11. Marital Status	12. Was Dec Armed F	cedent Eve	er in U.S. 13	B. Was Decedent of	Hispanic Origin? oan, Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)	0- 1	14. Race - Ame Black, White	
n Tygiene. do other then "naturel", or Items 23a or 28e-f show event, the Medical Examiner must be notified at	by Fu	1 Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 ☐ Yes If Yes, G Year or I	2 XNo		1 ☐ Yes 2 📉 No				Specify:	White
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Is marked other treumatic event, In	Be	17. Father's Name (First, Middle, Cletus Willia						Name (First, Middle Sephine I			n
mark	2	19a. Informant's Name/Relations			19b. Ma	iling Address (Stree		-			
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		20a. Method of Disposition		ł	20b. Place of Dis	position (Name of rematory or other pla	ace)	Date	20c. Loc	cation - City or	Town, State
ent: If ury or		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		1 State	Bethel	Church Ce	m. Aug	15,2007	Cas	scade,	MD
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

William F OX		1- For State Certificate of Death Registrar		g. No. 200	1 25551
Physicia	n/	1. Decedent's Name (First, Middle,Last)	Date of Death Month	Day Year	3. Time of Death 1752 hrs
Medical Examin	er	WILLIAM THOMAS FOX 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De	August 6, 2	4c. County of Death	
. /		Laurel Hospital Laurel		Prince George	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours M	Hrs. 8. Date of Birt	h(MM/DD/YYYY) 9. Bir Foreig	an l
Director		219-80-5590 1X M 2 F 42 Yrs.	APRIL	24,1965 ^{Co}	untry)MARYLAND
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
ind show a	ᅵ	MD. PRINCE GEORGES COLLEGE PARK			1 X Yes 2 No
Maryla 28a-f	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?
with the		4903 EDGEWOOD RD. 20740	C-asit Vac an Na	U.S.A.	ican Indian, Black,
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene. Gant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Oecedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Pue		White, etc.	ican indian, black,
after d	ð. F	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Date: 1 Yes 2 X No specify:		Specify: W]	HITE
hours		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16b. Kind of Business/	Industry
36 hin 72 e. than	Completed	11 LABORER		HOME IMPRO	OVEMENT
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121 d be fi fental narked event,	a l	THOMAS WILLIAM FOX JR. CAI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Street and Num		aGUE	Zin Code\
MD 212, rd 2 should be uth and Menta n 27 is marke	욘	CAROL J. FOX/MOTHER 5009 MUSKOGEE ST.,		-	
Baltimore, MD permit. Pages I and 2 sh Department of Health and Department of Health and Important: If item 27 is injury or other traumat	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	
Baltimore, permit. Pages I a Department of Permit Department of the Important: If ite important: If ite		Burlar 2 A Cremation 3 Removal from State	-14-2007	RIVERDAL	E, MD.
Salti ermit. Separtn mport	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FIINERAL	HOME & C	REMATORIUM	,P.A.
Physician	-	M00091 5801 CLEVELAND A 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	VE., RIVE	RDALE, MD.	20737 Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic cardiovascular disease			Between Onset and Death
Examiner	-	or condition resulting in death) Due to (or as a consequence of):			
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68760, certificate be nding physici		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre	gnancy	23d. Date of deliver Month	y Day Year
Box 687 e death certific the attending	icial	past 12 months? 4 Pregnant at time of 5 Other (Specify)			,
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rds, require	Completed		24a. Was a		topsy findings available completion of cause of
eco he law ate has	d L		perform	med? death?	es 2 No
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Division of Vital Records, tal or attending Physician: The law requir is after death. al Director: After this certificate has been so led in by the funeral director, page 2 should be		1 V Yes 2 No Inpatient 2 V ER/Outpatient 3 DOA Nu		Residence 6 Othe	r:
on o	<u>ë</u>	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No		, ,	
ViSic or Atte frer dea birecto	licat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S or Town, Si		ural Route Number, City
Dipital of ours at ours at filled i	Certification:	4 Homicide determined (Specify)			
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a constant of the control of the	and due to the cause ed at the time, date a	e(s) and manner as stated and place, and due to the	ed. ne cause(s)
To t with To t	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
		Mal-xCCVR, O.C.M.E.		August 8, 2007	
· R		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 31. Date filed (Month, Day Year) 32. Registrar's Signature		ME	
Sta Registi		AUG 1 3 2007 Been D. Specks	00	716	

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

			Please Type of						•	le.	
			For	of Maryland				/lental Hyg	jiene		
	_		State Registrar		Cei	rtificate of	Death	2. Date of Dea	leg. No.	11	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last)	o T				Month 7/30/2	Day	Year	10:00 A M
V.,	/Medic		John Elliott Georg 4a. Facility Name (If not institution, give street and			4h. Citv. Town. o	r Location of Death	1/30/4	4c. County o	f Death	10:00 A
	Examin	er	2752 Sudlersville Rd.	, nambor)		Sudler			Quee		ne
100	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Vear	9. Birthp	lace (State or Foreign
	Director		214-34-5983 ¹ ∑ M 2□	^F 68	Yrs.	Wortens Days	Flours Will.	Oct. 23	1938		yland
	and **		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	Maryl f sho ied a	tor	MD Queen Anne	Su	dlers	ville					1 ☐ Yes 2 X No
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Cour	itry?
	th witl	2752 Sudlersville Rd. 21668 USA									
	ems er mu									- Americ	an Indian, etc.
ဂ္ဂ	s afte										ite
2-003p	hour tural		15. Decedent's Education		16a. Deced	dent's Usual Occup	pation		16b. Kind of Bus	iness/in	dustry
5	nin 72 In "na Medic	Completed	(Specify only highest grade complete		(Give life. l	kind of work done DO NOT use retired	during most of work d)	king			•
7	d with giene er tha , the	Som	12 2	Je (1 40/ 51)	Farm	er			Agricu	1tur	е
and	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam)	
<u> </u>	i Men i Men i Men narke	To	John Elliott George,		401 11 11			Cruiksha			
<u>g</u>	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relationship (Type. Print)				and Number or Rui				
a)	Heali Heali tem 2 other		Penny George/ wife 20a. Method of Disposition	20b. Plac	ce of Dispo	sition (Name of	ille Road	Date Sudle:	rsville, 20c. Location - 0		
baltimor	Pages ent of nt: If I		15☐ Bunal 2 ☐ Cremation 3 ☐ Removal for 4 ☐ Donation 5 ☐ Other (Specify)	rom State	-	natory or other pla .11e Ceme	tery 8-3-	2007	Sudlersv	ille	, MD
	permit. P Departm Importar any Injui		21. Signature of Funeral Service Licensee	5			ss of Facility Fe		Helfenbe	in δ	Newnam
מ	De la		Kick of Hely	le de		130 Spe	er Rd.	Chester	town, MD	216	20
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	nat caused the death. on each line.	Do not ent	•	1		rest,		Approximate Interval Between Panset and Death
, I	Physician		Immediate Cause (Final disease or condition resulting in death)	devoca		ma s	tomae	ch			Sunta
	/Medical Examiner		Due	e to (or as a conseque	nce of):						
k		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	e to (or as a conseque	nce of):					-	
	executed in and ial-transit	Examiner	that initiated events C.								
Ď,	e exe		resulting in death) Last	e to (or as a conseque	nce of):						
00/0	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	d							-	
×	ding p	/Me	IF FEMALE: 23c. If yes	, outcome pf pregnanc	CV				23d. Date	of dollar	201
Ž Q	death e atten	cian	in the past 12 months?	ive birth 2 ☐ Fetal d regnant at time of dea	leath 3	Ectopic pregnancy Other (specify)	у		Mon		Day Year
į.	t the c	hysi	9 ☐ Unknown 9 ☐ L	Inknown							
ν, T	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions contributing	to death but not resulti	ing in the u	nderlying cause giv	en in Part I.	23e. Did to			ne cause of death?
cords	equire			_				1 🗆 Y	es 2 → No	3 Prob	ably 4 Unknown
ပ္ပ	2 55 0	Completed						24a. Was autop	Sy Di	rior to co	psy findings available mpletion of cause of
	sician: The law s certificate has b irector, page 2 s							perfoi 1⊟ Yes		eath? □Yes	2□ No
	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	48	7/0	oth	26. Place of Dear				
5	\$ # P	ı: To	27. Manner of Death 28a. [ate of Injury 2	8b. Time o	IL 3 DOA	4 LI Nursing H		ence 6 Othe		у)
SION	ath. rr: Afte	atio	1 Natural 5 Pending (2 Accident investigation	Month, Day Year)	injury		Yes 2 □ No				
<u> </u>	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. F	Place of injury - At homouilding, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Numbe	r or Rura	al Route Number,
	oital o urs aff eral D										
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To 2 Medical Examiner: On tand								
	To the within To the comple	Me	29b. Signature and title of certifier	1		29c. Licens	se number		29d. Date/signed	(Month,	Day, Year)
)			> Own down			DE	7887		7/3/	10	/
	15		30. Name and address of person who completed	cause of death (Item 2	3a) (Type,	Print)	1.0.1	, /	7/1/		1) M) 4/620
	Sta	te.	31. Date filed (Month, Day, Year)	32. Register's Signatur	hurc	h Hill K	a. Zurke	100	nestert	un	M) 21620
	Registr		AUG 0 1 200	32. Regist tr's Signatur	A.S.	And o					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydione

			For State Registrar	state of Ma	•	•	nent of H cate of I	ealth and N Death	-	giene Reg. No.	7)17	26556	
	Physicia		Decedent's Name (First, Middle, Last)	D	-				2. Date of De Month AUGUST	ath OI	Year	3. Time of Death	
	/Medic	al .	JEAN LOROTHY GERO 4a. Facility Name (If not institution, give stre			4b.	City, Town, or	Location of Death	AUGUSI		2007 County of Deat	4.10 1.	
	Examin	er	CARRIAGE HILL BETHE			E	BETHESD.	A		MO	NTGOMER		
ę.	Funeral Director		5. Social Security Number 6. Sex	7. Age	(In yrs. last birt		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da October	rth ay, Year) 9. Birthplace (State or Foreign Country) 26, 1908 Pennsylvania			
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locatio	n					10d. Inside City Limits	
	Maryli -f sho iled al	tor	Maryland Montgomery		Bethesda	a						1 ∐Yes 2√∑No	
	or 28a	Directo	10e. Street and Number	1		10	Of. Zip Code			10g. Citiz	en of What Co	ountry?	
	ath wi		5215 Cedar Lane				20814			USA	4. Race - Ame	ricon Indian	
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			s, specify Cubs	ispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Black, White		
215-0036	nin 72 hou .n "natura Medical E	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed) College (1-4or 5-	1.17	Decedent's (Give kind life. DO N	s Usual Occup of work done o IOT use retired	ation during most of work t)	king	16b. Kir	nd of Business/	/Industry	
7	led with tygiene her tha nt, the I	Com	12			mstres	s		(=:	Garm			
Maryland	eve d	Be	17. Father's Name (First, Middle, Last) Michael Gallucci					18. Mother's Nam		, Maiden i	Surname)		
Š	s 1 and 2 should be f Health and Mental Item 27 Is marked o other traumatic eve	ဥ	19a. Informant's Name/Relationship (Type	. Print)	19b	. Mailing Ad			a Tobio ural Route Number, City or Town, State, Zip Code)				
	nd 2 alth a 27 ls		Antonia Maria Schierling/Daughter 2 Cumbernauld Court, Rockville, MD 20850								850		
altimore,	0 O		20a. Method of Disposition 1. □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State									Town, State	
Ĕ	tment of tant: If It		3 St. Catherine's Cenetery August 6, 2007 Moscow, Pennsylvania 21 Signature of Funeral Service Licensee 22 Name and Address of Facility 22 Name and Address of Facility										
Ra	permit. Pag Department Important: I any injury o										OOO1 Approximate		
ı			shock, or heart Milure. List only one cause on each line. Immediate Cause (Final										
	Physician /Medical		disease or condition resulting in death)	DEPILITY Due to (or as	a consequence	of):							
	Examiner		Daniel de la constitución de la	TRANSIEN	on conservations.	SERVICE OF	TTACKS						
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as i	s our sequence								
	xecute and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
68760,	icate be executed physician and s the burial-transit	edical E	d.C	CORONARY	ARTERY	DISE	ASE						
P.O. Box 6	ath certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)							2	23d. Date of delivery Month Day Year		
	uires that the de signed by the a id be detached i	by	Part II. Other significant conditions control OSTEOPOROSIS, ADVAI					ven in Part I.				o the cause of death? robably 4 ☐Unknown	
3ecor	ie law require has been sig je 2 should b	Completed	HISTORY OF MYOCARD	IAL INFA	RCTION				24a. Was		prior to death?	utopsy findings available completion of cause of	
a	10 ==		25. Was case referred to medical					26. Place of Dea	1□ Yes	2 X No	1 □ Yes	s 2[X]No	
Ž	ysicia Is certi directo	To Be	examiner?	ospital: 1 ☐ Inpatie	ent 2 ER/Ou	rtpatient 3	B DOA Oth		lome 5 ☐ Res		6 □Other (Spe	ecify)	
Division or Vital Records,	ng Ph ifter th ineral	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		Time of Injury	28c. Inju Wo M 1 [28d. Describe				
Divis	al or Atte s after des al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injubulding, etc.	ury - At home, fa c. (Specify)	ırm, street,	factory, office		28f. Location City or To	(Street an own, State	d Number or R	lural Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examina	cian: To the best er: On the basis of and manner sta	f examination ar	a, death oc nd/or invest	curred at the ti	me, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) e, date and	and manner a d place, and du	is stated. le to the cause(s)	
	To the within To the complex c	Me	29b. Signature and title of centifier	9 0			29c. Licens D3557				te signed <i>(Mon</i> 3/02/20		
(8	100 P		30. Name and address of person who con SUSAN J. MILLER, MD		leath (Item 23a) ULIP HI	(Type, Prin LLTER	RACE, I	BETHESDA,	MD 208	16			
	Sta Regist		31. Date filed (Month, Day, Year) AUG 0 6 20		ar's Signature	San	ed.						

		-	For State Registrar		Stat	e of Ma	ıryland			nt of H		nd Me	ntal Hyg	iene g. No.	07	26557	
30	C Division	F	1. Decedent's Nam	ne (First, Middle	, Last)							2.	Date of Deat Month	h Day	Year	3. Time of Death	
	Physicia /Medic		MARY	EMILY	GASC	H						J	uly 31	, 2007		2:06 a M	
	Examin		4a. Facility Name (4b. City	, Town, or	Location of I	Death		4c. County	of Death		
		2	Larkin 5. Social Security N	Chase	Nursing 6.Sex		(Im .um I	ast birthday)		wie or1 Year	If Under 24	Hrs a	Date of Birth	Princ		orge's	
	Funeral ` Director		577-01-4		1 M 2 X			Yrs.	Months			Min.	(Month, Day,		Cou	yland	
3		t	Usual Residence of				88		1				01-23-	1919	Mal	y land	_
	how		10a. State	10b. County			10c. City	, Town or Lo	cation							10d. Inside City Limits	
	e Ma	cto	Maryland	Calve	rt		Ow:	ings								1 ☐ Yes 2 X No	
	or 24	Director	10e. Street and Nu							ip Code			1	0g. Citizen of		ntry?	
	e 23e	ra	9635 Sou	ith Poi		t Decedent B	Tunnin III	10		0736	annaia Origin	o? (Coooid	y Yes or No-	U.S.A.		can Indian.	_
	item item	Funeral	11. Marital Status 1 □ Never Mari	ried 2⊡ Marri	Arme	ed Forces?		5. 13.	If Yes, sp	ecify Cuba	n, Mexican, I	Puerto Rio	an, etc.)		ck, White,		
920	urs af	þ	3 X Widowed		l It Ye	s, Give or Dates:			1 🗌 Yes	2 X No	Specify:			Specia	v: Whi	.te	
5	filed within 72 hours after death with the Maryland Hygiene. ther than 'natural', or iteme 23a or 28a-f show int, the Madical Examiner must be mullified at	Completed	/Sno	15. Decedent		ated)		16a. Dece	dent's Us	ual Occupa	ation furing most o	of working		16b. Kind of E	Business/In	dustry	_
2	ithin 7	nple	Elementary/Sec		1	ge (1-4or 5	+)	life.	DO NOT	use retired)					rge's Cty.	
2	lygier her th	S	17. Father's Name	/Fires Adiabate	(====)			Mana	ger S	Schoo	1 Cafe			Public Maiden Suma		ools	_
and	od la b	Be	Joseph I											walderi Surra	ille)		
2	2 should be filed within 72 hours after death with the Marylan and Menth Hygiens, is marked other than "natural", or iteme 23a or 28a-f show annatic event, the Marical Examiner must be notified at	2	19a. Informant's N			r)		19b. Mailii	na Addre	ss (Street a		th Ow		, City or Town	. State. Zii	c Code)	_
<u>8</u>	ges 1 and 2 should it of Health and Men if item 27 is marke or other traumatic		James A.			,			-	•				gs, MD			
ē,	of Health of Health Fitem 27 r other tra		20a. Method of Dis	•			20b. P	lace of Dispo emetery, cre	sition (N	ame of	1	Dat		20c. Location			_
Ë	permit. Pages Department of I important: if its any injury or o			Cremation 5 ☐ Other (S _i		from State		t Linco			1	8-03-	2007	Brentw	ood.	Maryland	
Baltimore, Maryland 21215-0036	permit. Departn Imports any inju		21. Signature of F	un rai Service	Licensee		- 1				s of Facility			4739	Balt:	imore Ave.	
<u> </u>	82.58		de		m	17C	135						, P.A.		sville	, MD 20781	_
9).	Physician /Medical	2	23a. Part1. Enter shock, or her Immediate Cause disease or conditi resulting in death)	(Final	a	that caused on each ling ue to (or as	12	2me	ter the mo	ode of dying	g, such as ca	ardiac or r	espiratory arr	est,		Approximate Interval Between Onset and Death	
	Examiner	Ş.				30 10 (01 00	2 00110041	30.100 01).									
		ner	Sequentially list contains to the cause. Enter Und Cause (Disease o	onditions, immediate lerving	D	e to [or as	a consequ	ience of						-			
	ocuted nd transl	Examiner	that initiated eveni	(S	c												_
90,	cate be executed obysicien and the burial-transit	ũ	resulting in death)	Last	U	ue to (or as	a consequ	ience of):									
8760,	physicate t	dle			d												
Box 6	± Do α	Physician/Medical	IF FEMALE: 23b. Was decede	nt orognant	23c. If ye	s, outcome	of pregna	ncy						23d. D	ate of deliv	rerv	
	thet the death cer ed by the ettendir detached for use	clar	in the past 12	2 months?	4	Live birth Pregnant at			⊒Ectopic ⊒ Other (pregnancy specify)					lonth	Day Year	
о. О.	by the drached	hys	9 Unknow		9[_	Unknown			11.1								_
	res the igned be del	by P	Part II. Other sign	ificant condition	ons contributing	g to death b	ut not resi	ulting in the u	underlying	cause give	en in Part I.					the cause of death?	
ord	w requir been si should											_	1 🗆 Y	es 2 No	3 ☐ Pro	bably 4 Unknown	-
ec	elawi hasbo je 2 st	Completed											24a. Was a autop	SV	prior to co	opsy findings available ompletion of cause of)
<u> </u>	The												1 ☐ Yes	med? 2 No	death?	2 🗆 No	
Division of Vital Records,	Attending Physician: r death. sctor: After this certifice by the funerel director.	Be	25. Was case refe examiner?	-	Hospital:					Oth			Check only or				-
ō	Phys r this srel di	To To	1 ☐ Yes 2 ☐ 27. Manner of Dea	No ath	28a.	1 Inpatie	ry	ER/Outpatie 28b. Time of		28c. Injun Wor	4 1919013			ence 6 🗆 0		ity)	-
lo	nding th. :: Afte e fune	tor	1 Natural 2 Accident	5 🗌 Pendir investi	ng	(Month, Da	y Year)	Injury	М		k? Yes 2∐N	lo					
Vis	or Atter ter des lirector	Iffe	3 Suicide	6 ☐ Could determ		Place of Inj		ome, farm, st	reet, fact	ory, office		28	If. Location (S City or Tow		nber or Rui	ral Route Number,	_
ō	itel or is after rai Dire	Certification:				January, 60	. (Opeon)							/			
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)				fexamina									stated. to the cause(s)	
	To the within 2 To the complet	W	29b. Signature an	d title of certifie	, A				2	9c. Licens	e number)		9d. Date sign	ed (Month	, Day, Year)	
Λ			▶ W.	JUNI	N					1771	7/8	_		02	200	1	
K	(10)		30. Name and add	-	who complete	d cause of o	leath (Item	23a) (Type	Print)	6.11	ne	Rd	A312	8-2- -Bor	12	MY	
	St.	ate	31. Date filed (Mo	onth, Day, Year)	ave K	32. Registr	ar's Signa	iture	170							2-110	-
	Regist		AUG 0	2 2007	Bare	32. Registr	1. 1	rede	1								

			State of State of State of State of State of State Aregistrar/Amend#19a.PerFHPCO8-8-0	Maryland	/ Depa		lealth and M	lental Hygi	•	26558			
	Physici /Medic	-	1. Decedent's Name (First, Middle, Last) Susie A. Griffin					2. Date of Death Month July 27	Day Ye	ar 6:40 A ^M			
	Examir					4b. City, Town, of Hyatts If Under 1 Year Months Days	Location of Death Ville If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		George 's Birthplace (State or Foreign Country)			
100	Director		577−58−7708 1	74	Yrs. Town or Lo		Hours Min.	Nov. 15,	1932	Georgia 10d. Inside City Limits			
4	or 28a-f	Director	District of Columbia 10e. Street and Number	Wash	ingto	10f. Zip Code		10	g. Citizen of What	11√2 Yes 2 □ No Country?			
	tural, or iteme 23a	by Funerai	711 - 7th Street, NE 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decerated Armed For 1 Yes If Yes, Give Year or Da	2 [X] No		20002 Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:		Black, V	tates wnencan Indian, ^{/hite} Affrican- American			
215-0	within 72 to ane. then "natur he Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-		(Giva	dent's Usual Occup kind of work done OO NOT use retired	turing most of work	ing 1	6b. Kind of Busine	ess/industry			
22	tal Hygi d other event,	To Be Corr	5 years 17. Father's Name (First, Middle, Last) Oscar Griffin, Sr.			isabled	18. Mother's Name		N/A laiden Sumame)				
e, Mary	permit. Pages 1 and 2 should be 1 Department of Health and Mental I important: If Item 27 is marked of eny injury or other traumatic eve once.		19a. Informant's Name/Relationship (Type, Print) Ella M. Admans Sister 19b. Mailing Address (Street and Number or Rural Route Number, City 723 - 7th Street, NE Washington, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c.)							, DC 20002			
Baltimore,			20a. Method of Disposition 1	tate cerr	oln M	lem. Cemet	e) tery Aug.	7, 2007		nd, MD			
			23a. Part I. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock; releart failure. List only one cause on each line. Atherogal arotics. Heart Disease.										
	hysician /Medical ixaminer	er	disease or condition resulting in death) Due to (conditions)	or as a consequent	nce of):	neart Dis	sease						
68760,	physician and the burial-transit	cai Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a conseque									
Box	a atter	Completed by Physician/Medi	230. Was decedent pregnant 1 Live bit	ome of pregnanc th 2 ∐Fetal de int at time of deat wn	eath 3[Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year			
	igned be del	ed by Pl	Part II. Other significant conditions contributing to dea Hypertension, Hypothyro		-					e to the cause of death? Probably 4 □Unknown			
I Reco	ate has b	Complet	Fibrillation, Schizopha	asia				24a. Was an autopsy perform	prior ed? deatl	e autopsy findings available to completion of cause of n? Yes 2 . No			
of Vita	is certific director.	To Be		patient 2 EF		t 3 DOA Oth	er: 4 🂢 Nursing Ho		nce 6 Other (S	Specify)			
ivision	After	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	n, Day Year)	8b. Time of Injury e, farm, str	Worl	/ at √? Yes 2 □ No	28f. Location (Stre City or Town,	eet and Number o	r Rural Route Number,			
_ estimated	4 1 0	edicai C	29a. Certifier (Cireck Only one) 1 Certifying Physician: To the la	sis of examination	edge, death n and/or in	occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)			
Toth	withi Comp	Me	- VICOU	W Er	ur		number 45 8 77 6	29	d. Date signed (M	onth, Day, Year)			
L	3) Sta	10	30. Name and address of person who completed cause Doris V. Pablo-Bustos, M. 31. Date filed (Month, Day, Year)		0 Var		NE #213 T	Vashingto	on, DC 20	0017			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			State of Mai		ertificate of	Death	Reg.	21111	26559			
	Dhysisi	20	Decedent's Name (First, Middle, Lest)	14	1		2. Date of Deeth	Day Year	3. Time of Death			
	Physici /Medio		Alan Kobin N	0175:	Man			2007	0815			
>	Examir	ner	4a. Facility Name (If not institution, give street end number) 7001 Kenhill RJ			4b. City, Town, or Loc 13 e H, e		Monty:	omery			
	Funeral Director		5. Social Security Number 6. Sex 128-56-3574 124 M 2 F 7. Age ((In yrs. last birthday 57 Yrs.	y) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 10/30/194	9. Birth Cou 19 Was	place (State or Foreign ntry) hington DC			
	land			I0c. City, Town or L	Location				10d. Inside City Limits			
	Mery Befish	ţo	MD Montgomery I	Bethesda					Y☐ Yes 2☐ No			
	or 28	Direc	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	ntry?			
	ath w	rai	7001 Kenhill Road		20817			ited Stat				
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Heatth and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1. Marital Status 1. Married 2 Married 3 Widowed 4 Divorced 1. Was Decedent Event Armed Forces? 1. Yes 2 Mo If Yes, Give Year or Dates:	er in U,S.	Was Decedent of H If Yes, specify Cubs 1 □ Yes X □ No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	cify Yes or No- lican, etc.)	14. Race - Ameri Black, White Specify: Whi	etc.			
Baltimore, Maryland 21215-0020	vithin 72 ho ne. hen "natul e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)	(Giv	edent's Usual Occup re kind of work done DO NOT use retired	eation during most of working d)	g	. Kind of Business/Ir	ndustry			
Q 0	filed v Hygie ther ti		17. Father's Name (First, Middle, Last)			18. Mother's Name						
an	lid be ental ked o	To Be	Max Holtzman			Elsie Lo		 ,				
ary	and M s mar	-	19a. Informant's Name/Relationship (Type, Print)									
Σ,	and 2 ealth a n 27 is		Karen E. Holtzman - Sister			ce NW Wash						
lore	tges 1 nt of He if item or oth		20a. Method of Disposition 1 □}Burial 2 □ Cremation 3 □ Removal from State		position (Name of ematory or other plac			. Location - City or T	own, State			
₫	it. Pa irtmer rtant: njury		4 ☐Donation 5 ☐Other (Specify) 21. Signature of Funeral Service Licensee		rid Mem. G		3/15/2007	Falls C	hurch, VA			
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90,	be ex	a E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Original or injury that initiated events									
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Division of Vital Records,	To the Hospitel or Attending Physicien: The law within 24 hours efter death. To the Funeral Director After this certificete has completely filled in by the funeral director, page 2	ition: To	27. Manner of Death 1. Natural 5 Pending 2 Accident Pending (Month, Day Y.	28b. Time	of 28c. Injur	4 LI Nuising Hom	e 5 Residence Bd. Describe how i	e 6 □Other (Speci injury occurred	fy)			
Divisi	el or Attending Ph s efter death. al Director: After thi ed in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (a	- At home, farm, s Specify)	street, factory, office	28	Bf. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,			
	To the Hospitel or within 24 hours efter To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of many and manner stated	camination and/or in								
	withii comp	Σ	29b. Signature and title of certifier		29c. Licens		29d.	Date signed (Month,				
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_	10	_	30. Name and address of person who completed cause of deat JRA N BRECKER, M	h (Item 23a) (Type	F. Print) 210 E 5,10	,	my paik	0 2090	ンプ			
	Sta Registra	_	31. Date filed (Month, Day, Year) 32. Registrar's AUG 1 2007	Signature	uli	,						

DHMH 17 Rev 1/2001

Registrar

AUG 0 3

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Robert Carlton Howard 3. August 4:00 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 3255 Mills Pond Drive Port Republic Calvert County f Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 11/30/1938 9. Birthplace (State or Foreign **№** M 2□F Hours Months Days 577-52-7788 68 Washington, D.C. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Calvert Port Republic 10e. Street and Number 10g. Citizen of What Country? 3255 Mills Pond Drive 20676 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a Plumber | Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Robert Howard Mildred C. Hudson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irma Howard/Wife 3255 Mills Pond Dr. Port Republic MD 20676 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 08/06/2007 Suitland. MD 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Lee 8125 Southern Md Blvd., Owings MD 20736 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Poncreati disease or condition resulting in death) 4 months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 □Unknown

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

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28a-f

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items 23a

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Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Examiner must be notified at

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ely filled in by the fu within 24 hours and
To the Funeral DI

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

						<u> </u>		24a. Was an autopsy performed? 1□ Yes 2⊅\No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No				
	Was case referr examiner?	ed to medical		26. Place of Death (Check only one)									
	1 Yes 2 2 K	No	Hos	spital: 1 ☐ Inpatient 2	☐ ER/Outpatient	ome 51X2 Residence 6	ne 5X Residence 6 □Other (Specify)						
	Manner of Death X Natura! 2	5 Pending investigation		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred				
	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined		28e. Place of injury - At building, etc. (Spe	home, farm, stree cify)	et, fact	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,					
29a	. Certifier	1 Certifying Ph	ysic	ian: To the best of my k	nowledge, death	occurr	ed at the time, date and place	, and due to the cause(s)	and manner as stated.				

29b. Signature and title of certifie

29c. License number D0059061

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

August 3, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arati C. Patel 31. Date filed (Month, Day, Year) 110 Hospital Road, Suite #212, Prince Frederick, MD 20678 M.D.

State Registrar

Medical

32. Registrans Signature 2007 AUG

15

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after daath.

To the Funaral Director: Aftar this certifica

3altimore, Maryland 21215-0020

EB State Registrar 29b. Signature and title of certifier

VIJAY KARUMBUNATHAN 31. Date filed (Month th, Day, Year) AUG 0 6 32. Registrar's Signature 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201 Hall Highway Cristield MD 21817

29c. License number

D 43098

29d. Date signed (Month, Day, Year)

		For State Registrar		State o	f Marylan	-	rtment of H	Health and N Death		giene Reg. No.	107	26564
		1. Decedent's Name	e (First, Middle, La	st)					2. Date of De	ath Day	Year	3. Time of Death
Physici /Medic		Edward	С.	Hibberd					July	- 1	2007	12:10 PM
Examin	er		URY REHAE	8 & N	URSING		SAL	ISBURY, M	ID. 2180	4	nty of Death WICO	
Funeral Director		5. Social Security N 188-24-60 Usual Residence of	053	ex M 2□F	7. Age (In yrs. 76	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 04/25/	y, Year)	Coun	lace (State or Foreign htry) sylvania
/land		10a. State	10b. County		10c. Cit	y, Town or Loc	ation				1	0d. Inside City Limits
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or 28)Ire	10e. Street and Nu				•	10f. Zip Code			10g. Citizen	of What Coun	ntry?
ath w	ral	200 Ci	vic Avenu	T				21804			USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene Important: if Item 27 is marked other then "neturel", or Iteme 23s or 28s-f show any injury or other treumatic event, the Medical Examinal rount to notified at ODGe.	by Funeral Director	11. Marital Status Never Marr 3 □ Widowed	ied 2 Married	12. Was Dece Armed Fo 1 Tyes If Yes, Gin Year or D	2 X No		Vas Decedent of H Yes, specify Cub ☐ Yes 2 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Spe	Race - Americ Black, White, cify: Whi	etc.
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D d day	Be	17. Father's Name						18. Mother's Nam			name)	
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Depermine Permine Perm		anos)	L Winn	101/2	M00295			ers of Facility neral Homo erset Ave		noga Ar	ano MI	21852
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after after Dire	ert	4 🗌 Homicide	determined	buildi	ng, etc. (Specif	(y)	,,,		City or To	wn, State)		
To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical C	29a. Certifier (Check only one)	1 Certifying Pl 2 Medical Exam	niner: On the b	best of my kno asis of examina ner stated.	owledge, death ition and/or inv	occurred at the trestigation, in my	me, date and place opinion, death occur	, and due to the rred at the time,	cause(s) and date and place	manner as st ce, and due to	tated. the cause(s)
withir To th	Me	29b. Signature and	title of certifier	1 ./-			29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)
		12	2/1	1///	3		0	2 8 74	-1	7/	3/N	7
		30. Name and add	ress of person who	co pleted caus	se of death (Item	п 23а) (Туре, і	Print)	1.1	/	1	6 1	
EB			ROBINS,				SALISBU	RY, MD.	21804			
Sta		31. Date filed (Mor			eg strar's Signa	ature	1					
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Registrar DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** BETTY JANE WILKES HARRELL 30 2007 12:37A JULY /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES CLINTON, MD SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1□M 2**X**F 19,1943 NORTH CARO MARCH 242-70-2936 Director LINA Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1XX es 2 □ No PRINCE GEORGES OXON HILL MD Director 10g. Citizen of What Country? 10e Street and Number 20709 5433 WOODLAND BLVD. U.S.A Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after on nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Specify: BLACK 1 ☐ Yes 2 ☐XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DISTRICT OF COLUMBIA College (1-4or 5+) than Elementary/Secondary (0-12) SCHOOL SYSTEM TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Menta EVA G. WILKES NATHANIEL DUNCAN other traumatic ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5433 WOODLAND BLVD. OXON HILL,MD 20709 JEROME K. HARRELL/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State ARLINGTON, VA CEM8/7/07 ARLINGTON NAT. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility STRICKLAND FUNERAL SERVICES 21. Signature of Funeral Service 6500 ALLENTOWN RD. CAMP SPRINGS, MD 20748 uwart mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the Disease shock, or heart milure. Immediate Cause (Final adeno Carrinang with Mets to live UNKNOWY) naclenal **Physician** Advanced disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-tra Due to (or as a consequence of): Physician/Medical as the IF FEMALE: asn 23c, If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Year Month Day for in the past 12 months? 5 Other (specify) ☐Yes 2. No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 【No 24a. Was an autopsy page 2 1∏ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 X Inpatient Certification: To this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? After (Month, Day Year) or Attending 5 ☐ Pending investigation 1 Natural ospital c.
4 hours after dec.
regal Director: Andre dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide hin 24 hours after the Funeral Dire npletely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

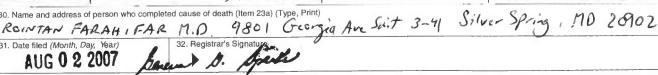
Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

State Registrar 31. Date filed (Month, Day, Year) AUG 0 2 2007

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NO.

To

29c. License number

1) 43446

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8:14 PM Brenda James Darlene 2007 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Hagerstonn / If Under 1 Year If Under 24 Hrs. MD Washington 5. Social Security Number County Hospital 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) 04/28/1954 Year) Days Hours WEST VIRGINIA 1 ☐ M 2 🕱 F 53 234-90-8196 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No BERKELEY MARTINSBURG 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number LISA 25404 406C COTTAGE RD., BLDG 144 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify. Specify: 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSING ASSISTANT MEDICAL 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WAGER F. PENWELL SARAH E. ENGLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. BOX 1682 MARTINSBURG, WV 25402 FRANK W. JAMES. JR. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State TRINITY LUTHERAN CEMETERY 08/10/2007 RFD, MARTINSBURG, WV 4 ☐ Donation 5 ☐ Other (Specify) of Facility BROWN FUNERAL HOME, P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 22. Name and Address of Facility 21. Signature of Funeral Service Licensee harles Drouen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respirator wech Due to (or as a nsequence of): Stroke week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No 3 Probably 4 Unknown Mollitu 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 100 1∐ Yes 26. Place of Death (Check only one 25. Was case referred to medical examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

2

Examiner

Completed by Physician/Medical

Be

Medical Certification: To

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygleine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examinary.

The law requires that the death certificate be executed for use as the burial-tran Division or Vital Records, P.O. Box 68760, aftending physician signed by the aid be detached for

or Attending Physician;

should peen page 2 s certificate director, this After thi funeral (within 24 hours after death

To the Funeral Director:
completely filled in by the 1

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

> 5 Pending investigation

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28d. Describe how injury occurred

29a, Certifier (Check only one)

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

4 T Homicide

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D65488

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and a dress of person who completed cause of leath (Item 23a) (Type, Print)

Antictan St. Hagerstown MD 21740

State Registrar

Paman
31. Date filed (Month, Day, 1)

6 Could not be determined

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July Physician 2007 Jones 31, Anna 4:08 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Frederick Calvert Calvert County Nursing Ctr. 7. Age (In yrs. last birthday)
OA Yrs. Months Days Hours Min. Mar. 8, 1921 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 216-22-2784 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or Iteme 23s or 28s-f ehow The Medical Examiner must be notified at Owings 1 Yes 2 No MD Calvert Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 8880 Grover Turn Lane 20736 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 I No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Someone Else's al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Home Pages 1 and 2 should be filed w riment of Health and Mental Hygien rtant: If Item 27 is marked other ti njury or other treumatic event, ID 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Amy Major Emerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owings, MD 20736 8880 Grover Turn Lane Oscar Gray/nephew injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of important: If eny injury or once. Mt. Hope UMC Cem. 8/7/2007 Sunderland, MD 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Fred., MD20678 21. Signature of Funeral Service Licensee Servell Sladys Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atheroscienotic Cardio Vascular dicease **Physician** /Medical Due to (or as a consequence of): Examiner Dertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner ettending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificete be executed Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 Tyes 2 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the e P.0. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Dementia Advance 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 3 No Division of Vital : After this certification of funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4因Nursing Home 5日Residence 6日Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA S 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending efter death.

Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours eft To the Funeral Di completely filled in Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 50653 7-31-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road. 5851 Deale Church 32. Registras Signature 31. Date filed (Month, Day, Year) State 2007 AUG Registrar

Eugene Joseph		State of Maryland / Department of Health and Mental For State Certificate of Death Registrar			7 2656
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last) Eugene Joseph Jones, III	2. Date of Death		3. Time of Death 2214 hrs
E.		4a. Facility Name (if not institution, give street and number) 8110 MLK Jr. Hwy 4b. City, Town, or Location of Dea Glenardon	Month I July 27, 200	4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H 218-29-9185 16 Yrs. Months Days Hours Mi		(MM/DD/YYYY) 9. Bir Foreig	thplace (State or in untryMaryland
nnd sshow any 110e.	7	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Prince George's District Heights			10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f show notitied at once.	Il Director	10e. Street and Number 10f. Zip Code 7206 Donnell Place, Apt. B-7 20747	3.5.	. Citizen of What Cou United Sta	
ific: death wi al", or items?	y Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 11. Yes 2 X No 2 X No 3 Page 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes 2 X No specify:		14. Race - Ameri White, etc.	can Indian, Black, .ck
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 nours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", 3r items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Student		16b. Kind of Business/	industry
1215-0036 I be filed within 7 ental Hygiene. arked other than vent, the Medica	Be	17. Father's Name (First, Middle, Last) Calvin Adams Cynt	ne (First, Middle, Ma hia Jones	aiden Surname)	
MD 21 nd 2 should ' alth and Mei m 27 is mai	T ₀	19a. Informant's Name/Relationship (Type, Print) Cynthia Juanita Jones/Mother 19b. Mailing Address (Street and Number of 7206 Donnell Place,	Apt. B-7	- District	Hgts.,MD
Baltimore, permit. Pages I an Department of Hee Important: If ite		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial 8	/4/07	20c. Location - City or Suitland,	Maryland
		21. Signature of Funeral Service Licensee Charles E. Yours Moo 981 5538 Marlboro Pik	e, Forest	ville, MD	20748
Physician /Medical (aminer		23a. Part I. Enter the disease, failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wounds (2) to Chest and Leg Due to (or as a consequence of):	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course			
uted nd ransit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
50, te be executed ysician and burial - transit	ledical	UNPENDED AMENDED		102d Data af daliusa	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death within 24 douts after death To the Finneral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the but	sicial	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 9 Unknown	nancy	23d. Date of deliver Month	y Day Year
ords, P.O. E wrequires that the d s been signed by the should be detached	ed by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Yes	acco use contribute to 2 ✓ No 3 Pro	bably 4 Unknown
Division of Vital Records, tall or Attending Physician: The law requirers after death an Director: After this certificate has been silled in by the funeral director, page 2 should be in by the funeral director, page 2 should be a second to the control of the co	Completed		24a. Was at autops perforn 1 ✓ Yes 2	y prior to ned? death?	utopsy findings available completion of cause of es 2 No
Vital ysician: this certifi director,	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 26. Place of Death (Check of Death		Residence 6 🗸 Othe	r: Scene
ion of Vi ttending Physi leath ttor: After this	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury FOUND: Day, Year) FOUND: Day, Year) FOUND: 2207 hrs 1 Yes 2 No	28d. Describe ho Subject shot	ow injury occurred	
Division Hospital or Attend 24 hours after death Fruneral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Multi-Family Apt.	or Town, Sta		ural Route Number, City
To the Hos within 24 h To the Fun completely	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, as well as we			
	ž	29b. Signature and title of certifier 29c. License number O.C.M.E.		July 28, 2007	nth, Day,Year)
CR(3)		 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212 	201		

State 31. Date filed (Month, Day Year Registrar AUG 0 2 2007

32. Registrar's Signature.

			1 - State Amend Ite	State of Maryla m 25 per me,	nd / Depa g871 _067	rtment of Hi	ealth and M Beath	lental Hygi	ene 007	26569
	Physic		1. Decedent's Name (First, Middle, Last) $EDTTH$	JONI	ES			2. Date of Death July 2	8, Day 2007	3. Time of Death 1910 M
)	/Medi Examir		4a. Facility Name (If not institution, give s Calvert Memor		a 1	4b. City, Town, or Prince	Location of Death		4c. County of Death Calvert	
	Funeral Director		5. Social Security Number 6. Sex 216-50-5920		. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Oct., Pay,	O Bish	pplace (State or Foreign intry) MD
	e Maryland Sa-f ehow	ctor	Usual Residence of Decedent		ity, Town or Lo Ches	cation apeake I	Beach			10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	h with th	ai Dire	10e. Street and Number 4051 Christia:	na Parran I	Road	10f. Zip Code 2073	32	10	g. Citizen of What Cou USA	untry?
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hyglene. Important: if item 27 is marked other then "natural", or iteme 23s or 28s-1 show say fourty or other treumatic event, if a Medical Examinar must be notified at Ance.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	[Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B1	, etc.
21215-0036	within 72 ho lene. r then "netui the Medical	ompieted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Deced (Give lite. L	lent's Usual Occupa kind of work done di DO NOT use retired) Housewi	uring most of work	ing 1	6b. Kind of Business/li	•
Maryland 2	wild be filed Mental Hyg arked other atic evant,	To Be C	17. Father's Name (First, Middle, Last) $John$	Rawl	lings		18. Mother's Name Sarah		laiden Sumame) rown	
	in and 2 sh Heelth and tem 27 le m other treum		19a. Informant's Name/Relationship (Ty) Charles Jones/: 20a. Method of Disposition	son	Wald	g Address (Street a 1 Oak Ma orf, MD sition (Name of	20601		City or Town, State, Zi	
Baltimore,	it. Peges rtment of rtant: If it njury or o	and the same	1 ☑ Surial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Wa	ard s	UMC Cem.	8/4/	2007	Owings, M	ID
Ba	Depe Impo eny ii		21. Signature of Funeral Service License Bladys A-	Sevell						ed.,MD2067
68760,	Physician /Medical Examiner but style paral-transit style paral-t	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of): quence of):	D. 5204	onen	nog	the Tito	Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death centificate thes been signed by the etiending phy page 2 should be deteched for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	CE (CE) (Ectopic pregnancy (Other (specify)	WEIGHE		23d. Date of delin	very Day Year
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al Reco	ician: The law r certificete hes be rector, page 2 sh	Completed						24a. Was an autopsy perform 1 Yes 12	ed? prior to co	opsy findings available ompletion of cause of
Division of Vital Records,	ding Phyen. After this funeral di	ation: To Be	25. Was case referred to medical examiner? 1 Tes 2 H 27. Maner of Death	ospital: Inpatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	t 3 DOA Other	4 Nursing no		nce 6 Other (Spec	(fy)
DIVIS	at or Attenses efter death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, stre	eet, factory, office		28f. Location (Street) City or Town,	eet and Number or Rui State)	al Route Number,
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}	To To con	×	29b. Signature and title of certifier M	000		29c. License			d. Date signed (Month)	
	3		30. Name and address of person who con	MENDOUGH	6	RIADCIE	I-RE	L ROAD DERILL		20678.
F	Sta Registr		31. Date filed (Month, Day, Year) AUG	32. Registrate Sign	ature	Spartie)				

		State of Maryland / Department of I State of Maryland / Department of I Certificate of			ene 007	26570
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last) MARY JO McDONALD KENNEY 4a. Facility Name (If not institution, give street and number) 4b. City, Town,	or Location of Death	2. Date of Death Month AUGUST	Day Year 6, 2007 4c. County of Death	3. Time of Death 18:41 M
Funeral	E1	KLINE HOSPICE HOUSE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Dave	MT. AIRY	8. Date of Birth (Month, Day,	CARROLL Year) 9. Birthy Cou	place (State or Foreign
Director		579-42-0804 1 M 2 W F 76 Yrs. World Is a says Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		5/10/1		INGTON, DC
th the Mary or 28a-1 sh e notified	Irector	WV BERKELEY MARTINSBURG 10e. Street and Number 10f. Zip Code		10	g. Citizen of What Cou	1 □ Yes 2X No
parificions, interpretations and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23e or 28e-f show eny injury or other treumatic event, the Modical Exeminer must be notified at once.	Funeral Director	62 RUMS EY TERRACE 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 2 Married 1 Never Married 2 Married 3 Married 3 Married 4 Married 4 Married 5 Married 5 Married 5 Married 5 Married 5 Married 6 Married 7 Married 8 Married	5401 Hispanic Origin? (Spe ban, Mexican, Puerto	acify Yes or No- Rican, etc.)	USA 14. Race - Ameri Black, White,	etc.
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all yiai	ToB	DAVID J. BELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street	t and Number or Rura		City or Town, State, Zip	
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parmit. Pages permit. Pages Department of important: if it eny injury or o		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Addr Chaules M. Bland 327 W. KING	8/10/2 Pess of Facility BRO G ST., MARTIN	OWN FUNERAL	SMITHSBURG, LHOME, P.O. 1 25402	
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	ing, such as cardiac c	or respiratory arre:	st,	Approximate Interval Between Onset and Death
The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 shruid be detached for use as the burial-transit	Physician/Medical Ex	Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 Yes 2 No 9 Unknown Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) 1	су		23d. Date of delive Month	ery Day Year
requires the	ρχ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	ıven in Part I.	1 Yes		bably 4 Unknown
vital nec	e Completed	25. Was case referred to medical	26. Place of Death	24a. Was an autopsy perform	ed? / prior to co death? ✓ No 1 ☐ Yes	opsy findings available impletion of cause of
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To the Hoscitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Str. City or Town,	eet and Number or Run State)	al Route Number,
To the Host Itel or within 24 hours afte To the Funerel Dir completely filled in	Medica	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the table of the control of the basis of examination and/or investigation, in my and manner stated.	opinion, death occurr	ed at the time, da	te and place, and due t	o the cause(s)
	-	W N	12207	42	d. Date signed (Month,	07
19		30. Name and ddre s of person who completed cause of death (Item 23a) (Type, Print) SUL RT PTVE, MARTINSBURG V 25401 31. Date filed (Month, Day, Year) 32. Registrar's Signature	MICA	MI	MD	
Sta Registra		AUG 1 7 2007 Com If Spell				

07-05806 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jamai Purnell Throck Morton State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 29, 2007 Medical Examiner Jamal Purnell Throck Morton 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Route 50 at Mile Marker 77 Trappe 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** Min Director Months 215-15-1863 1 x M 24 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location MD Baltimore hours after death with the Maryland Director 10e Street and Number 10g. Citizen of What Country? 10f, Zip Code 5910 Laclede Rd. 21206 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married Married Yes 2 X No Divorced If Yes, Give Year Widowed Yes 2 X No specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) be filed within 72 Baltimore, MD 21215-0036 Chef permit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other transmatic event, the Medi 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Sumame) Randolph Throck Morton, Sr. Be Edna Purnell 70 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Morton/mother 415 Dighton Avenue, Snow Hill, MD 21863 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 08/05/2007 Mt. Wesley UMC Donation 5 Other Specify: Cemete Tyme and Address of Facility 21. Signature of Funeral Service Licenses Lewis N. Watson Funeral Home Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas **Physician** failure. List only one cause on each line /Medical a. Multiple Injuries Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical tending physician a use as the burial -UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₫ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? ✓ Yes 2

Division of Vital Records, P.O. Box 68760. within 24 hours after death To the Funeral Director:

Be

٩ funeral

Certification:

State Registrar

3

After this

the

filled in by

25. Was case referred to medical

1 Yes

2 🗸 Accident

27. Manner of Death

Natural

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifier

Carol Allan, MD

PAR

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 30, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Redistrar's Signature **ORIGINAL**

26.Place of Death (Check only one

Nursing Home 5

Other4

Yes 2 V No

28c. Injury at Work?

Time of Death

0840 hrs

10d. Inside City Limits X Yes 2 No

Approximate Interval

Between Onset and

Year

4c. County of Death Talbot

1983

Foreign

14. Race - American Indian, Black,

Black

White, etc.

16b. Kind of Business/Industry

Restaurant

20c, Location - City or Town, State

Snow Hill, MD

23d. Date of delivery

Dav

24b. Were autopsy findings available

death?

Residence 6 Other: Scene

28f. Location (Street and Number or Rural Route Number, City

1 Yes

prior to completion of cause of

Month

No

Driver auto fixed object collision

or Town, State) Route 50 @ Mile Marker 77, Tappe, MD

28d. Describe how injury occurred

Country) MD

Hospital:

Pending

Investigation

Could not be

determined

Inpatient 2

(Specify) Interstate/Express

28a. Date of Injury (Month, Day, Year) FOUND:

Jul 29, 2007

ER/Outpatient 3

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

FOUND:

0819 hrs

CI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

harles J. Musse	1	State of Maryland / Depar 1-For State <i>Certi</i>		of Health and Meni		an No	5 17					
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of Dea		V	3. Time of Death				
ledical Examir		Charles J. Musser			Month August 1,	Day 2007	Year	0628 hrs				
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of	of Death		ounty of Deat	th				
		Bayside Avenue / Mercer Avenue		Ingleside	r 24Hrs. 8. Date of Bi	Ken		irthologo (Stato or				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday	Months Days Hours	Min.	,	Fore	ian				
Director	-	222-22-0172 1 X M 2 F 65 Usual Residence of Decedent		Yrs.	Sept.	9, 19	41	ountry)Delaware				
any	-	10a. State 10b. County 10c. City, T	own or Le	ocation				10d. Inside City Limits				
	٦	Maryland Queen Annes Inge	1side	2				1 Yes 2 X No				
faryland 28a-f sho 1 at once.	당	10e. Street and Number		10f. Zip Code	1	l0g. Citizen	of What Co	untry?				
3a or	吉	320 Ell Morris Road		21644	=	Unite	d Stat	es				
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene. Inter of Health and Mental Hygiene and "natural", or items 23a or 28a-f she or other tranmatic event, the Medical Examiner must be notified at once or other tranmatic event, the Medical Examiner.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	. 13.	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican)- 14	. Race - Ame White, etc.	erican Indian, Black,				
or ite	ᇤ	1 Yes 2 X No				Co	T.Th					
rs afte ural",	2	Widowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade completed)	16a Decr	Yes 2 X No specify:			ecify: Wh					
2 hours a	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		ng most of working life. DO NOT				1-21-1-12-2				
036 Ithin 7 ne.	ם	12	Seli	Employed		Con	struct	ion				
5-0 led wi Hygie other	-	17. Father's Name (First, Middle, Last)		18.Mother	's Name (First, Middle,	Maiden Su	mame)					
21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'e event, the Medical	a	Charles A. Musser	T	Carm	elita Brown	1	T 01-	7: 0-4-)				
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med	-1	19a. Informant's Name/Relationship (Type, Print)	1	ailing Address (Street and Nun		te, Zip Code)						
mand 2 sho lealth and tem 27 is traumati	1		lace of Di	E11 Morris RD.,	Ingleside, Mi Date	20c. Loc	ation - City o	or Town, State				
nore ges 1 at of H t: If i		X Buttal 2 Cremation 5 Kemova nom State		or other place) ok Cemetery	August 6,	LI i 1m	inator	n, Delaware				
Baltimore, permit. Pages 1 at Department of Hee Important: If ite		4 Donation 5 Other Specify: SILIV		22. Name and Address of Facilit	2007	IMTTIII	ingto					
Balti permit. Departn Imports		MO1353		Mealey Funeral Hon	ne P.O. Box 2	.866 . V	Vilmingt	19805 con, DE.				
Physician		sa. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and										
/Medical xaminer		Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease Death										
Adminion		or condition resulting in death) Due to (or as a consequence of)):									
	<u>ة</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of)):					_				
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated										
ted insit		events resulting in death) Last Due to (or as a consequence of)):									
50, te be executed nysician and	ledical	UNPENDED AMENDED										
68760, certificate be nding physici	Med	IF FEMALE: 23c. If yes, outcome of pregn	nancy		<u> </u>	23d. 1	Date of delive	ery				
tox 6876 eath certificate eath certificate eath certificate or attending phy	jan/	23b. Was decedent pregnant in the past 12 months?	2 _		c pregnancy	М	lonth	Day Year				
Box e death c the atten ed for us	Physician/N	1 Yes 2 No 9 Unknown g Unknown	^{atn} 5	Other (Specify)								
- 4 ≥4		Part II. Other significant conditions contributing to death but not re	sulting in	the underlying cause given in P	art I. 23e. Did	tobacco us	e contribute	to the cause of death?				
F. P.O ires that t signed by	Completed by	Diabetes mellitus	_		1 Y	es 2 l	No 3 P	robably 4 🗸 Unknown				
ords, w requir	를	H			24a. Wa auto	s an opsy		autopsy findings available o completion of cause of				
eco he law ate has age 2 s	E E			·		formed?	death′ 1 ✓					
of Vital Records, ng Physician: The law requir ther this certificate has been s neral director, page 2 should	Be	25. Was case referred to medical examiner?			(Check only one)							
n of Vital I ling Physician: After this certiff funeral director,	10 E	1 Yes 2 No Tospital 1 Inpatient 2	ER/Outpa		Nursing Home 5		ce 6 🗸 Oti	ner: Scene				
n of ding Pl After funera		(Month, Day, Year)	28b. 1 m	e of Injury 28c. Injury at Wor	-	e now injury	/ occurred					
5 g g s 2	cati	2 Accident Investigation	mo farm	street, factory, office building, e		(Street and	Number or	Rural Route Number, City				
	Certification:	Suicide Could not be determined (Specify)	nne, iaim	street, factory, office building, e	or Town,		Trainiber of	rear reare rearrants, only				
E S E E		29a. Certifier	e, death	occurred at the time, date and p	lace, and due to the car	use(s) and	manner as s	tated.				
To the Hospita within 24 hours To the Funeral completely fille	Medical	(Check only one) 2 Medical Examiner: On the basis of examination are and manner stated.	nd/or inve	stigation, in my opinion, death o	ccurred at the time, dat	e and place	e, and due to	the cause(s)				
E 3 E 3	ĕ	29b. Signature and title of certifier		29c. License numbe		29d. Da	ate signed (/	Month, Day, Year)				
		Fatricia Inonia- Fol	leh	O.C.M.E.		Augu	st 2, 2007	7				
		30. Name and address of person who completed cause of death (Item		a. 111 Dann Street D	altimore MD 040	01						
	لبي	Patricia Aronica-Pollak MD. Assistant Medical E 31. Date filed (Month, Day, Year) 32. Begistrar's Signatu		er 111 Penn Street, B	alumore, MD 212	UΙ						
Si Regis	tate trar		2 1	cash								
DHMH 17 Rev 1/2	001	AUG 3 2007 Streets D	ORIG	INAL								

DHMH 17 Rev 1/2001 OCME 2006

OCME

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 3

32. Registra s Signature

007

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Aug 4 2007 William J. Morris бам /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 420 Clay Hammond Road Calvert Prince Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 □ F 81 **Director** 727-03-4470 Dec 10 1925 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □ Yes 2 □ No Director Maryland Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20678 United States 420 Clay Hammond Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1↓□ Yes 2□ No If Yes, Give Year or Dates: 45-4 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: white 2 45 - 483 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) construction carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental H Louise Shifflet Alfred Morris 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (0) permit. Pages 1 and 2 a Department of Health an Important: If Item 27 is any Injury or other trau Robert Shifflett - nephew 420 Clay Hammond Road Prince Frederick MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Asbury Cemetery Aug 8 2007 Barstow Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Rausch Funeral Home Brauso 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a complete the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a complete the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final anoma Tas Pati **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner -transit The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 🗌 Yes 2X No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 No Hospital or Attending Physician: funeral director Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? P⊟ Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated To the within 2 29b. Signature and title of 30. Name and addre of person 100 Hospital Rd, Suite 310 Prince 31. Date filed (Month, Day, Registra State Registrar AUG

			For State Registrar	State of Maryland		artment of H			giene	07	26575
	Physici	an	Decedent's Name (First, Middle, Last) Harold Delaney Me	errvman				2. Date of Dea Month		Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give st	reet and number)			r Location of Death	Aug.	4c. Count	2007 y of Death	5:40 P M
	Funeral Director		Atlantic General 5. Social Security Number 578-36-9955 6. Sex	7. Age (In yrs. las	st birthday) Yrs.	Berlin If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 9	h v. Year)	9. Birthp Coun VA	elace (State or Foreign ntry)
	death with the Maryland ms 23a or 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Worcester	10c. City,	Town or Lo			J OUTY 5	, 1551		0d. Inside City Limits 1 ☐ Yes 2 🕱 No
	th with the 23e or 28 ust be not	Funeral Director	10e. Street and Number 12623 Shell Mill Ro			10f. Zip Code 21813	3		10g. Citizen of USA	What Coun	ntry?
960	hours after deal turs!, or items :	þ	11. Marital Status 1: 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		ce - Americ ack, White, fy:Whit	etc.
1215-0	n 72 "nai	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	king	16b. Kind of E		dustry
Maryland 21215-0036	be filed ital Hygi d other svent, 1	To Be Co	17. Father's Name (First, Middle, Last) Benjamin Russell N	Merryman	_ Supe	17 7 1 501		ne (First, Middle, Mae Thon	Maiden Suma		
	s 1 and 2 should b if Health and Ment item 27 is marked other trsumatics		19a. Informant's Name/Relationship (Type Romona Merryman (w. 20a. Method of Disposition	ife)	12623 ce of Dispo	Shell Mossition (Name of	ill Rd.,L	ot 62 B	D	ishop	ville ₂₁₈ d ₃
Baltimore,	permit. Pages 1 and 2 Depertment of Health a Important: If Item 27 is sny injury or other trea <u>pncs</u> .		1	moval from State	land	veterans Name and Address	Cem. 08-	07-2007	Hurloc	k, Ma	ryland
8	88 1 28		23a. Part1 Enter the disease, or complic shoot, or heart failure. List only one	ations that caused the death.	1	08 Willia	am St., E	Berlin, N	Md. 218		Approximate Interval Between
68760,	Physician pe executed (Medical personner) Wedical physicien and as the burial-transit	edicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conseque Due to (or as a conseque Due to (or as a conseque	drel ince of): A ince of): Sian	Intercontery D.					Onset and Death
P.O. Box	death cer e attendir d for use	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3[Ectopic pregnancy Other (specify)				ate of delive onth	ery Day Year
	w requires that the been signed by th should be detache	eted by P	Part II. Other significant conditions cont Conges five Heart	ributing to death but not result	ing in the u	nderlying cause giv	en in Part I.	10%	es 2□No	3 Prob	ne cause of death?
Division of Vital Records,	The la ate hes page 2		Atabetes Mall 25. Was case referred to medical	Primonary Di	GRESR			***	med? 2 No	Were auto prior to cor death? 1 Yes	psy findings available mpletion of cause of
Ξ		To Be	examiner?	ospital: 1 Inpatient 2 Ef	R/Outpaties	nt 319 DOA Oth	05	th <i>Check</i> only or ome 5 ☐ Resid		her (Specifi	iv)
sion o	To the Hospital or Attending Physwithin 2 hours eithed ath. To the Funsel Director: Afler this completely filled in by the funeral di	ation: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		8b. Time o Injury	f 28c. Injun Wor	y at	28d. Describe h			,,
Divis	Ital or Att rs efter de rst Directu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, st	reet, factory, office		28f. Location (S City or Tow	Street and Num m, State)	ber or Rura	i Route Number,
	the Hospi in 24 hou the Funsi ipletely fil	Medicai	(Check only 2 Medical Examine one)	cian: To the best of my knowler: On the basis of examinatio and manner stated.	edge, deat in and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the c rred at the time, c	cause(s) and made	anner as si , and due to	tated. the cause(s)
	To T To I	Σ.	29b. Signature and title of certifier	2 Theund		29c. Licens	8/30	ż	29d. Date sign	ed (Month,	Day, Year)
Pyl	4+1		30. Name and address of person who con	hopleted cause of death (Item 2	23a) (Type,	1	10 2	(8// J	effrey	Green	nwood, MD

Registrar

700: 17:40

DOB: 719/31 DOB: 8/2/07

Menymon, Haved D. 55# 578-31-9955

AUG 0 6 2007 Registrar's Signature

			For State Registrar	State of Ma	aryland	•	artment of I			ental Hy	giene Reg. No.		, (1 m)	on the s
J	Physici	an	Decedent's Name (First, Middle, JACQUELYN M	,						2. Date of De		in U d i	3. Time of 12:45	
	/Media	cal	4a. Facility Name (If not institution,	give street and number)			4b. City, Town,			0011	4c.	County of Deat	th	
	Funeral		3813 COPPERV 5. Social Security Number		je (In yrs. l	ast birthday)	If Under 1 Year	If Unde	GTON er 24 Hrs.	8. Date of Bi	rth	INCE G	thplace (State o	
į,	Director		217-60-6248 Usual Residence of Decedent	1□M ¾ ₩	56	Yrs.	Months Days	Hours	Min.	4 (Month 7)	*5°E**)	ALA	BAMA	
	aryland show	7	10a. State 10b. County	CEODGEC	1	, Town or Lo		.T					10d. Inside Ci	
	vith the M or 28a-f be notifie	Director	10e. Street and Number 3813 COPPER	GEORGES	FI	• WAS	10f. Zip Code 2074				_	zen of What Co		
(0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 □ Never Married ※ Married	12. Was Decedent Armed Forces?			Was Decedent of If Yes, specify Cul	Hispanic C pan, Mexic		ecify Yes or No Rican, etc.)		14. Race - Ame Black, Whit		
-003	hours a tural", o al Exam	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	If Yes, Give Year or Dates:			1 ☐ Yes 2 No dent's Usual Occu		y:		16h Ki	Specify: B	LACK	
21215-0036	d within 72 giene. r than "na the Medic	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	5+)	(Give life.	kind of work done DO NOT use retire IUE OFF	during me ed)				GOVERN	·	
	ld be filed ental Hyg ked othe ic event,	Be	17. Father's Name (First, Middle, L JOHN TOLBERT	ast)		-				(First, Middle				
Maryland	2 should and Me is mark aumatic	P.	19a. Informant's Name/Relationshi			1	ng Address (Stree	t and Num	ber or Rura		er, City o	r Town, State, 2		
	s 1 and f Health Item 27 other tr		TRUMAINE MAT 20a. Method of Disposition		20b. Pl		RITCHI esition (Name of matory or other pla			DISTF		HEIGH ecation - City or	<u>_</u>	2074
Baltimore,	t. Page dment o frant: If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.	ecify)	- 1	URREC	TION C	EM.	8/3/			NTON,M		
Bal	permi Depar Impor any Ir		21. Signature of Funeral Service L	Sawad			2. Name and Addr 500 AL					FUNERA SPRING		VICE 2074
	Discontinuo		23a. Part1. Enter the disease or shock, or heart failure. List Immediate Cause (Final						as cardiac o	r respiratory a	arrest,	8	Approximate Interval Bet Onset and I	ween
	Physician /Medical Examiner		disease or condition resulting in death)	a. CARDIO			RY ARRES	σT						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enier Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequ	ence of):								
oʻ	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequ	ence of):				1				
68760,		edical		d								-		
P.O. Box	the death certific / the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ₩ loop 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	су				23d. Date of de Month		⁄ear
	requires that the deatt een signed by the atte nould be detached for	þ	Part II. Other significant condition OBSTRUCTIV	•		lting in the u	nderlying cause gi	ven in Par	t I,			ise contribute to	the cause of d	
Records,	re The law requir icate has Leen si rr, page 2 should I	Completed	HYPERTENSI	ON						24a. Was auto perfi 1∐ Yes		prior to death?	utopsy findings completion of co	available ause of
Vital	siciar certi id rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	Hospital:			o Doc Ot			(Check only	one)			
o	ding Phys I. After this funeral di	on: To	27. Manner of Death 1	28a. Date of Inju	ıry	ER/Outpatier 28b. Time of Injury	f 28c. Inju	ıry at ork?	2	ne 5 🔀 Res 28d. Describe		6 □Other (Spe y occurred	cify)	
Division	I or Attending after death. Director: After in by the funer	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ation	ury - At ho c. <i>(Specify</i>	me, farm, str	M 1 C]Yes 2[28f. Location (City or To		d Number or Ru)	ural Route Num	ber,
	Hospita 24 hours Funeral etely filled	Medical Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis o and manner sta	f examinat	vledge, deat ion and/or in	h occurred at the t vestigation, in my	ime, date opinion, d	and place, a	and due to the ed at the time	cause(s)	and manner as d place, and due	s stated. e to the cause(s	3)
	To the within To the comple	Me	29b. Signature and title of certifier	Spurrag	r)		29c. Licen D0	se number			29d. Dat 8/1	te signed (Mont	h, Day, Year)	
y?	(0)		30. Name and address of person w					. OX	ON H	ILL, M	4D 2	0745		
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 2 2007	32. Registr					-		-,,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27° 2007^{ear} July 12 Ам Sheila Diane Muse 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Prince George's Cheverly 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1 □ M 2 F Months Days Hours 579-64-7814 60 June 8, 1947 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 12 Yes 2 □ No Maryland Prince George's District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 United States 1612 Tulip Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Anderson Walter M. Huntley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1612 Tulip Avenue, District Heights, MD 20747 Erika D. Briscoe / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 2, 2007 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licenses Washington, DC 20019 4001 Benning Road, NE 23a. Part1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebra a nox Due to (or as a consequence of): ardiac arre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown COTONAM Syndrome 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? beter Mell Itu. 2 **⊡** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Yes 27. Manne Death 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician

Physician

/Medical

Examiner

Funeral

Director

28a-f show

items 23a

"natural", or

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other events events

Examiner must be notified at

Director

Funeral

þ

Completed

Be

the Maryland

with ō

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examine Physician/Medical Completed by Be မ Certification:

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 Linatural 1 ☐ Yes 2 ☐ No 2 ☐ Accident Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie 29c. License riumber 29d. Date signed (Month, Day, Year)



To the Hospital

Boyce 31. Date filed (Month, Day, Year) AUG 0 2 2007 Registrar

WHIM

32. Registrar's Signatur

G Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Affer

within 24 hours after death

To the Funeral Director:
completely filled in by the

3001

Hospital DA. Cheverly md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** August 2ŎŨ7 9:50 P M Alice T. McCaffrey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Villa Rosa Nursing Home Mitchellville 8. Date of Birth (Month, Day, Year)
Nov. 7, 19 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days 1 □ M 2 🖺 F 93 1913 Virginia Director 225-10-1267 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits un "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Director Prince George Mitchellville Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20721 3800 Lotsford Vista Road death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 0 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ig g Bookkeeper Plumbing Pages 1 and 2 should be filed vent of Health and Mental Hygie int: If Item 27 is marked other to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William J. McCaffrey S. Madeline Richards 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If Item 27 is
any Injury or other trau. 311 S. Royal St., Alexandria, Virginia 22314 Judy Risdon, Niece 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 Removal from State St. Mary's Cemetery 4 □ Donation 5 □ Other (Specify) 8/6/07 Alexandria, Virginia 21. Signature of Funeral Service 22. Name and Address of Facility Jefferson Funeral Chapel braed 5755 Castlewellan Dr., Alexandria, Va. 22315 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause an each line. Immediate Cause (Final disease or condition resulting in death) erebrovascular Accident **Physician** 2-wecks /Medical Due to (or as a consequence of): Examiner Amerosclerosis Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 ☐ Unknowr signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Sich Sinus Syndrone 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate has autopsy performe Yes 2 1∐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Hospital or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide thin 24 hours a Medical 29a. Certifier 1 🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37934 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephanie Trifoglio MD 7500 (7500 Greenway Cente. Drive Green belt MD 20220

Registrar

State

Stephanie Trifoglio

31. Date filed (Month, Day, Year)

AUG 0 3 2007

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Charles L Martin 0240 M 28 2001 Tul /Medical 4c County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 6 201 Cheveria Prince Hospital Prince 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug 19 9. Birthplace (State or Foreign **Funeral** Days Hours Months MM 2 F 21 1985 Brooklyn NY 117-70-0809 Aug Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Bladensburg** ral", or items 23a or 28a-f sh Examiner must be notified MD Prince George's KZYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4243 58th Ave 20710 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black þ 1 ☐ Yes 2√ No Specify 3 ☐ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Mover Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta important: if item 27 is marked any injury or other traumatic ev Richard L Martin Crawford Penny ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
75 Vanderbulit Ave BLDG 9 Staten Island NY 10304 Vanderbulit Ave Penny Martin Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metropolitan Crematory 8-2-2007 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Alexandria Va 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pope Funeral Home 21 Signature of Funeral Service Licenses 2617 Penn Ave SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vehicle MOTOR /Medical Due to (or as a consequence of): Examiner Distress Syndrome Hdult Respiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ter this certificate has been signed in the certificate and director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Priv Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1njury or Attending 1 ☐ Natural 2 ☐ Accident tire hydrant July 26, 2007 2 No 1 Tes Director 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number City or Jown, State) 4 ☐ Homicide o the hc. within 24 hours. ▼¬ the Funeral D' 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Commedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 3001 32. Registrar's Signature State 3 2007 Registrar

Registrar

State

AUG 03 2007

DHMH 17 Rev 1/2001

32. Registrar's Sign dire

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Providence Hospital; DePaul Professional Bldg. Esmerando O. Juanitez, M.D.; Suite 008; 1160 Varnum Street, N.E.; Washington, D.C. 20017

CF (5)

State Registrar Khosrow Davachi, M.D. 7801 Old Branch Ave. #101 Clinton, Md.

31. Date filed (Month, Day, Year)

AUG 0 2 2007

AUG 0 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20735

07-05689 Michael Morris Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

Registrar				
Physician/ 1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day July 24, 2007	у Үеаг	3. Time of Death 2004 hrs
Medical Examiner Michael G. Morris 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location	n of Death	40. Godiny or Bodin	
Southern Maryland Hospital	rrs, last birthday) If Under 1 Year If Un	der 24Hrs. 8. Date of Birth(M	Prince George	
Director 062-50-0823 1XIM 2 F 51	rrs. last birthday) If Under 1 Year If Under		Foreig	untry) New York
Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Location			10d. Inside City Limits
Bullion Commons	Clinton	427 . 1		1 Yes 2 X No
MD. Prince Georges 10e. Street and Number 8212 Bellefonte Lane	10f. Zip Code	. 10g. (Citizen of What Cour	ntry?
MD. Prince Georges 10e. Street and Number 8212 Bellefonte Lane 11 Marital Status 12. Was Decedent Ever	20735 In U.S. 13. Was Decedent of Hispanic O	Origin? (Specify Yes of No-	U.S.A.	can Indian, Błack,
MD. Prince Georges 10e. Street and Number 10e. Street and Number 8212 Bellefonte Lane 11. Marital Status 12. Was Decedent Ever Armed Forces? 1	If Yes, specify Cuban, Mexica	an, Puerto Rican, etc.)	White, etc.	
3 Widowed 4 X Divorced if Yes, Give Year or Dates:	1 Yes 2 X No specific		Specify: Bla b. Kind of Business/	
15. Decedent's Education (Specify only highest grade complete	during most of working life. DO NO		D. Killa of Business/	industry
98 College (1-4 or 5+) 15. Decedents Education (specify only highest grade complete 15. Decedents Education (specify only highest grade complete 16. Decedents Education (specify only highest grade complete 17. Father's Name (First, Middle, Last)	Seafood Clerk		Store	
15. Decedent's Education (Specify only highest grade complete 15. Decedent's Education (Specify only highest grade complete 15. Decedent's Education (Specify only highest grade complete 16. Decedent's Education (Specify only highest grade complete 17. Father's Name (First, Middle, Last) 18. Lisiah Morris 19a. Informant's Name/Relationship (Type, Print)		ner's Name (First, Middle, Maid arion Gary	den Surname)	
TSiah Morris Usuah W Wental Day Lead of the Company of the Compan	19b. Mailing Address (Street and N		r, City or Town, State	e, Zip Code)
Kimberly Morris (Daughter)	8212 Bellefonte I		. 20735 Oc. Location - City or	Tour State
Kimberly Morris (Daughter) 10 1 20 20 Method of Disposition 1 XBurial 2 Cremation 3 Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)			
4 Donation 5 Other Specify: 21. Signature of Funeral Service Ucensee	Bethel Cemtery 22. Name and Address of Fac	2004	Alexandri	.a, vA.
B Ed III CHAHLK JOHNSON	311 N.Patrick	Lewis Funer St. Alexandri	a.VA	
Physician 23a art I. Enter the disease r complications that caused the	death. Do not enter the mode of dying, such a	s cardiac or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
Medical aminer In mediate Cause (Final disease or condition resulting in death) a. Gunshot Wound of Due to (or as a conseque			_	Death
Sequentially list conditions, b.	nce or).			
	nce of):			
Unlease or injury that initiated events resulting in death) Last Due to (or as a conseque	nce of):			
TE FEMALE: 23c. If yes, outcome o				
d. AMENDED AMENDED AMENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown		topic pregnancy	23d. Date of delive Month	Day Year
क के क्षेत्र हैं कि Part II. Other significant conditions contributing to death bu	t not resulting in the underlying cause given in			o the cause of death?
- 8 go o - 1				obably 4 Unknown
Records, The law requirer (frate has been sig. Completed		24a. Was an autopsy perform	prior to	autopsy findings available completion of cause of
Reco		1 ✓ Yes 2	No 1 🗸	
25. Was case referred to medical examiner?	26.Place of De 26.Pl	eath (Check only one) 4 Nursing Home 5 Re	esidence 6 Oth	er:
Description of the property o	28b. Time of Injury 28c. Injury at V	Vork? 28d. Describe hor Subject shot	w injury occurred	
1 Natural 5 Pending Jul 24, 2007	1930 hrs 1 Yes 2	2 ✓ No	net and Number or I	Rural Route Number, City
Division of Vital Records. 25. Was case referred to medical examiner? Division of Vital Records. Division of Vi	- At home, farm, street, factory, office building	or Town, Sta		
299 Certifier	nowledge, death occurred at the time, date an	d place, and due to the cause(s) and manner as st	ated.
Officek only one of the best of my kr one of the best of t	ation and/or investigation, in my opinion, deat	th occurred at the time, date ar	nd place, and due to	the cause(s)
29b. Monature and title of certifier	29c. License num O.C.M.E.		29d. Date signed (A July 25, 2007	нонин, Бау, геаг)
A Constitution of death address of person who completed cause of death	- = - = -			
Laron Locke MD. Assistant Medical Exam	iner 111 Penn Street, Baltimore	e, MD 21201		
State 31. Date filed (Mooth Day Year) Registrar 32. Registrar's	Signature			

Division or Vital Records, P.O. Box 68760.

with the Maryland

death

Baltimore, Maryland 21215-0036

within 2 0

or Attending Physician: The law requires that the death certificate be executed Certification: To death. after death Director; 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 12770 OLD LINE CENTER #207 WALDORF, MD 20602 PHALIP WISOTSKY, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 AUG 02 Registrar

			For State Registrar	State	e of M	aryland		artment of F			lental Hy	/giene	2007	26585
	Physici	an	1. Decedent's Name (First, Midd.	e, Last)	-						2. Date of D Month	eath Day	/ Year	3. Time of Death
	/Medic		DEVORA RIVLIN								Auc	13	3 2007	
	Examin	er	4a. Facility Name (If not institution					4b. City, Town, o		of Death			County of Dea	
	Francis		HEBREW HOME OF 5. Social Security Number	GREATER 6. Sex			N ast birthday)	ROCKVILI If Under 1 Year		24 Hrs.	8. Date of B		ONT GOME	RY tholace (State or Foreign
	Funeral Director		213-46-9062	1 ☐ M 2🔀		87	Yrs.	Months Days	Hours	Min.	8. Date of B (Month, D) 01/29/	1920	GER	thplace (State or Foreign ountry) MANY
	p.		Usual Residence of Decedent								-/-/			
	ehow	<u> </u>	10a. State 10b. County			10c. City	, Town or Lo	cation						10d. Inside City Limits 1 X Yes 2 □ No
	the Maryla 28a-f ehov	ectc	MARYLAND MONTG	OMERY		SILV	ER SP					10-03		
	with I	חַר	10e. Street and Number 13860 TURNMORE	ROAD				10f. Zip Code 20906				U.S.A	izen of What C	ountry?
	death w me 23a must	era	11. Marital Status	12. Was (Decedent	Ever in U.S	5. 13. 1	Was Decedent of H		igin? (Sp			14. Race - Am	erican Indian,
g	after or ite	Ţ	1 Never Married 2 Mar	ried 1 ☐ Y	d Forces?						Rican, etc.)		Black, Whi	
003	nours ural!	d by	3 ∑Widowed 4 ☐ Divorced	Year	, Give or Dates:			1 ☐ Yes 2 ဩ No	Specify:				Specify:	WHITE
7.	n 72 h	lete	15. Deceder (Specify only highe	t's Education st grade complet	ed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	ation during mos	t of work	ing		ind of Business	/Industry COUNTY
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene then "natural", or iteme 23a or 28a-f ehow nnt, the Madical Examiner must be notilied at	Be Completed by Funeral Director	Elementary/Secondary (0-12)	Collec	ge (1-4or:	5+)		ER'S AIDE					LIC SCH	
2	e filed I Hygi other	e C	17. Father's Name (First, Middle,	Last)			- LIIIOIII	or o mid		er's Name	e (First, Middle			
<u></u>	should be ind Mental marked o	To B	MAX HILZENROD						BERTH	IA MI	TTLER			
Maryland	s 1 and 2 should be filed. Health and Mental Hygitem 27 is marked other other treumatic event,		19a. Informant's Name/Relations					ng Address (Street						
	1 and 2 Health tem 27		JOSHUA RIVLIN/S	ON		205 01	American Inc.							YLAND 20906
Baltimore	iges 1 art of Height of Height or other		20a. Method of Disposition 1 Burial 2 □ Cremation		om State			sition (Name of natory or other place	ONC O		Oate /2007		cation - City or	
<u> </u>	it. Pa intmer intent		4 □ Donation 5 □ Other (S		- The	KING		O MEML GD			/2007	1		CH, VIRGINIA
œ œ	permit. Pages Depertment of t Important: If its eny injury or of once.		Vality of	Consee			DA	ANZANSKY 170 ROCVI	GOLDB	ERG	MEMORI	AL CI	HAPELS,	INC. AND 20852
			23a. Part1. Enter the disease, o shock or heart failure. List	complications th	nat cause	d the death							MARIL	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	only one cause	A		ICIA	IER I	FN	1=1	VTIA	_		Onset and Death
	/Medical		resulting in death)	Due Due	o (or as	a consequ	-	101-4	011	, ,	- 1 17 (\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
	Examiner	_	Sequentially list conditions,	b	CH	F								YEARS
	lsi ed	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	(or as	a consequ	ence ot):							YEARS
Two	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due	to (or as	a consequ	ence of):							10112
25 760	certificate be executed ding physician and use as the burial-transi	ical E												
68	n certificate anding phys use as the	ledic		- U										
Y X	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes		of pregnar		Ectopic pregnancy	,			:	23d. Date of de	
1/1/0	ie deatl the atte	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 □ P:		t time of de		Other (specify)					Month	Day Year
~ P. G.	that the do ed by the detached	F.	Part II. Other significant conditi	ons contribution	to death h	out not recu	fting in the u	nderhijna cauco an	en in Part I		23e Did	tobaccou	ise contribute t	o the cause of death?
	Attending Physicien: The law requires that the death death. sctor: After this certificate has been signed by the atter	Completed by Physician/Med	PERIPHE	RAL	_		ULA		FA	ST			□No 3□P	
Ö	w requires been sign should be	lete	OSTEOF	OROS	15			. 10			24a. Wa		_	utopsy findings available
√ / √ Vital Records	he lay e has	dmo	HURST	MYROL	218	M					auto	opsy ormed?	prior to death?	completion of cause of
	icien: Th certificete rector, pag	Be Co	25. Was case referred to medica		1)(26 Place	of Death	1 ☐ Yes	_	1 🗆 Ye	2 □ No
_	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	☐ Inpatie	ent 2 E	R/Outpatien	at 3□ DOA Oth	ac				6 ☐Other (Spe	ecify)
7	itending Physicien: The Jeath. tor: Alter this certificate hi the funeral director, page	:uo	27. Manner of Death 1 ⊠Natural 5 □ Pendii	28a. D	ate of Inju	ıry y Year)	28b. Time of Injury	28c. injur Wor	y at k?		28d. Describe	how injur	y occurred	
> is	tendi Jeath. tor: A the fu	cati	2 Accident investi	gation					Yes 2□					
\mathbb{Z}/\mathcal{L}	or At efter of Direct in by	Certification:	4 Homicide determ	inad 286. P	lace of Injuited	jury - At hor tc. (Specify)	me, farm, str	eet, factory, office			28t. Location City or To	(Street an own, State	d Number or R)	ural Route Number,
	To the Hospital or Atwithin 24 hours effer of To the Funerel Directompletely filled in by	al C	29a. Certifier 1 Certifyii	ng Physician: To	the best	of my know	vledge, death	occurred at the tir	ne, date an	id place,	and due to the	e cause(s)	and manner a	s stated.
	n 24 ł n 24 ł he Fu	Medical	(Check only 2 Medical one)	Examiner: On the	ne basis o nanner st	t examinati	ion and/or in	vestigation, in my o	pinion, dea	th occurr	ed at the time	, date and	place, and du	e to the cause(s)
	To the Hospital or Attend within 24 hours effer death To the Funerel Director; completely filled in by the fi	Σ	29b. Signature and title of certifie	r	/		.^ .	29c. Licens	e number	2~	,	29d. Dat	te signed (Mon	th, Day, Year)
			utn	e K	m	~/	14/	D	57	186	1	A	1091	3 200/
	3		30. Name and address of person	-nan-	cause of c	death (Item		Print) 21 WO	wah a	Se 1	2d =	LOCK	ville (29 20850
	Sta	te	31. Date filed (Month, Day, Year)		*	ar's Signat			17170	JC F	74	>-1	1108	0016
	Registr	_		107 Le	este	J.	Greek	D						

		Amend Items 230, 23, 27, 28, 28 Per mer 1, 1870, 08/1 Certificate of Death	2. Date of D		No.	3. Time of Death
Physiciar /Medica		1. Decedent's Name (First, Middle, Last) Evelyn Frances Reynolds	JMTy	30,	Day 007 Year	10:10 A
Examine		4a. Facility Name (If not institution, give street and number) Beverly Living Center 4b. City, Town, or Location of Dea Hagerstown	ith		4c. County of Dea Washing	gton
Funeral Director		5. Social Security Number 6. Sex 1 D M 2 TF 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hr Months Days Hours Mir		Sirth Day, Y	1930 Mai	thplace (State or Foreig ounta) ryland
Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Frederick Frederick				10d. Inside City Limit
ath with the Marylar 23s or 28s-f show	Funeral Director	10e. Street and Number 8520 Fingerboard Road 21704		1 -	. Citizen of What C	ountry?
ifter des	by Funer	11. Marital Status 1 Never Married 2 Married 3 X 4 idowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes & No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puell Yes, Sive Year or Dates:	Specify Yes or Norto Rican, etc.)	No-	14. Race - Am Black, Whi Specify: W	te, etc.
thin 72 ho e. an "netur Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	orking		b. Kind of Business	,
her ifed	Be Con		ame (First, Midd	le, Ma	Clothing	Factory
and Mer is marks	0	Joseph F. Knott, Sr. 19a. Informant's Name/Relationship (Type, Print) Patricia Wantz, daughter 19b. Mailing Address (Street and Number or F. 8520 Fingerboard Road)	Rural Route Num	nber, C		
ages 1 and 2 nt of Health t: If Item 27 f or other tr	ŀ	20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Paurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Maint Olivet Cametery Alic 2	Date	20	c. Location - City or	
permit. Pages Deportment of Important: If It any njury or o	I	21. Signature of Foreral Service Licensee MO0255 Amount of East Church S	rd PA Fu	ine	ral Home	1 701
Physician /Medical Examiner	ner.	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardinations, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Statu well of Spine Spin	ac or respiratory	arrest	,	Approximate Interval Between Onset and Death Onset Approximation (Control of the Control of the
hysicie	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Spinal Fracture Due to (or as a consequence of): d.	ROVED BY MEDIC			
that the death certific ed by the attending p detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 2 Fetal death 3 Ectopic pregnancy 5 Other (specify)		•	23d. Date of de Month	elivery Day Year
v requires that been signed b should be deta	ed by Pr	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.				o the cause of death? Probably 4 Ounknow
iclan: The law requerificate has been rectificate has been rector, page 2 should be a shou	e Complet	25. Was case referred to medical 26. Place of D	pe 1 ☐ Yes	topsy rforme 2.	prior to	
ding Phys	90	examiner?	28d. Describ	siden	ce 6 Other (Spinjury occurred	ecify)
rs efte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Yard	8520 Fi	ing	State) erboard R	Rural Route Number, MD d.,Frederi
To the Hospital within 24 hours of To the Funerell completely filled	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc and manner stated. 29b. Signature and title of certifier	curred at the tim	e, date	se(s) and manner as and place, and du	e to the cause(s)
T W T O	-	29b. Signature and title of certifier 29c. License number D2\$365 30. Name and address of cerson who completed cause of death (Item 23a) (Type, Print) MAW 2AA 36. Registrar's Signature 31. Date filed (Month, Day, Year)			7-3 Heigerste	
	,	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 2,29d per doc e870 8-17-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 200Zar Month Day **Physician** e len /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Yland DAI 5. Social Security Number If Under 1 Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Days 216-22-3312 Yrs. Director Jan.16,1929 Marvland 78 Usual Residence of Decedent 10h. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1**X**Yes 2 □ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 'natural', or Items 23a 711 Springdale Avenue 21403 United States by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ Yho
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. item 27 is marked other than Homemaker O<u>wn Home</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Franklin Williams Margaret Beatrice Wahab ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph F. Rodowsky/Husband 711 Springdale Ave., Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cemetery 7/23/07 Baltimore, Maryland 21. Signator of Funeral Service Lice 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St., Annapolis, MD 21401 Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) 1140 /Medical Due to (or as a consequence of): Examiner 1errysynA1 sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o Examine The law requires that the death certificate be executed erlebr attending physician and for use as the burial-tra Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) signed by the a Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has Leen s ye 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy ate ha perform 1 Yes 2 No Division or Vital Hospital or Attending Physician: director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this (28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No after death.

| Director: / 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aff To the Funeral D completely filled in Equifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year 2007 29b. Signature and title of certifier 29c. License number 5 30. Name and address of person who completed caute of the 123a) (Type, Print) strar's Signature 3 Date filed (Month, Day, Year)

Registrar

JUL 2 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 3 22:00PM Gary J.Rinehart 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMOre Kosedale Franklin SQUARE HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Sept. 27,1954 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 218-64-7498 52 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director MD Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 21787 USA Grand Drive Completed by Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No 光*iNEhraRT , 白*むy Baltimore, Maryland 21215-0036 Specify 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10 College (1-4or 5+) Remodeled Houses Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rita Miller Howard L.Rinehart 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1210 Georgetown Rd. Littlestown, PA17340 Richard L.Rinehart-Brother 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition Aug.2,2007 Hampstead.MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 21. Signature of Funeral Service Licenspe 22. Name and Address of Facility 34 Maple Ave.Littlestown, PA17340 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACUIE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ۵ MKNOWA Sequentially list conditions, if any, leading to immediate cause. Energy the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical

holesterolemia

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Year Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autops 1∐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? Injury

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 🗌 No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

1 🗌 Yes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Franklin Square DR Bothmore Maryland Terrell DR Mercedes 31. Date filed (Month, Day, Year)

State Registrar

88 attending for use as

signed by the a

cate has t page 2 s

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

To the

<u>\$</u>

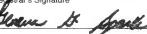
Completed

Be

Certification: To

Medical

AUG 0 3 2007



NJL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Terry 2007 Richard Roberts August

Physician

/Medical

	Examir	ier		r not mattution, give		•		4b. Oity, Town,		n Deali		40. Ooun	ty or beat	
	Funeral	1	5. Social Security N	Maryl	and Blv	d . Age (In yrs. I	ast birthday	OW11	r If Under:	24 Hrs. 8.	Date of Birth	3	ver	hplace (State or Foreign
	Funeral Director		213-66-3	1	X M 2□F	52	Yrs.	Months Day	s Hours	Min.	(Month, Day 2-14-1	r, Year)	Co	h., D.C.
	0		Usual Residence of	Decedent									_ nab	
	irylan show	_	10a. State	10b. County		10c. City	, Town or L	ocation						10d. Inside City Limits
	e Ma Ba-f s	Director	MD	Calvert				Owings						1 ☐ Yes 2 X No
	ith th	Dire	10e. Street and Nur	mber				10f. Zip Code				10g. Citizen o	f What Co	untry?
	ath w	ra		ithern Mar)736			US		deservation
	item ner n	Funeral	11. Marital Status	ied 2□ Married	12. Was Deceder	3?	S. 13.	Was Decedent of If Yes, specify Cu	iban, Mexicar	gin? (Specify n, Puerto Ric	an, etc.)	Bt Bt	ace - Ame lack, White	rican Indian, e, etc.
0000	rs aff	by F	3 Widowed	_	1 Types 2 [If Yes, Give Year or Dates	: 1076	Ω1	1 ☐ Yes 2 🔀 N	Specify:			Spec	ify: wh	ite
ž	2 hou atura cal E	ted	- 10	15. Decedent's Ed	ucation	1570-	16a. Dece	dent's Usual Occ	upation		-	16b. Kind of		
017	e. an "n Medi	ple	Elementary/Seco	orify only highest gra- endary (0-12)	ae compietea) College (1-4a	r 5+)	life.	e kind of work don DO NOT use reti	e auring mosi red)	t of working				
7	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed			1	·	Opera	ting Eng						pitality
alla	d oth	Be		(First, Middle, Last)						•	irst, Middle,	Maiden Surna		
<u>X</u>	2 should and Men is marke aumatic	은				r.				ella				ankins
<u>a</u>	l 2 sh h and l is m			ame/Relationship (7			1	ing Address (Street						
ב ט	1 and Health em 27 ther tr		20a. Method of Disp	Garner, E	riena	20h P		Souther		Date Date		20c. Location		
5	ages nt of l		1 ☐ Burial 2	Cremation 3		eı		osition (Name of matory or other p					•	
Dallinor	it. Partmel		21	5 ☐ Other (Specify IneraL Service Licen		Allo	-	Gifts Re				Hanove		
0	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Fu	O Carr	P CI			2. Name and Add	77	Raus	ch Fur	neral H	lome,	P.A.
	17 - 160		23a. Part I. Enter t	he disease, or comp	olications that caus	ed the death		325 Mt.				_	<u>10 20</u>	Approximate
4lo	Dhysisian	2.7	Immediate Cause (Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	'n		as a consequ		ashic ianc	V				_	8 musths
	Examiner						201,00 01,							
	No.	Je.	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nditions, nmediate	Due to (or a	ıs a consequ	uence of):							
	cuted nd ransit	Examiner	Cause (Disease or that initiated events	injury	C									
5	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	EX	resulting in death) l	Last	Due to (or a	as a consequ	uence of):				-			
00/00	ate be hysici he bu	Physician/Medical			d									
	ertific ling p e as t	Mec	IF FEMALE:											
אַ מכי	ath o	ian/	23b. Was deceden in the past 12		23c. If yes, outcom	2 Fetal	I death 3	⊒Ectopic pregnar	псу			1	Date of del Month	livery Day Year
	the de	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregnant 9□Unknowr		eatn 5	Other (specify)						
ŗ	that the ed by detac		Part II. Other signit	ficant conditions o	ontributing to death	but not resu	alting in the	underlying cause (given in Part I.		23e. Did to	bacco use co	ntribute to	the cause of death?
Ď,	uires sign d be	d by									1 📑 🕻	es 2□ No	3 🗌 Pı	robably 4 Unknown
niosa	w req beer shou	Completed									24a. Was	an 24h	n Were au	itonsy findings available
ב	he la e has ige 2	ፎ						·			autor	rmed? 2 No	death?	utopsy findings available completion of cause of
8	an: T tificate or, pa	ပို	25. Was case refer	red to medical					26 Place	of Death (C			1 □ Yes	2 No
>	ysicle s cert direct	ToB	examiner? 1 ☐ Yes 2 ☐		Hospital:	itient 2	ER/Outpatie	nt 3□ DOA	ther.			lence 6 🗆 0	ther (Sne	cifv)
5	g Ph		27. Manner of Deat		28a. Date of I	njury Day Year)	28b. Time	of 28c. In	-			now injury occ		,,
2	ath. or: Aff	atio	1 ☐ Natural 2 ☐ Accident	5 Pending Investigation		say reary	ingury		Yes 2	No				
2	er der recto	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	20e. Place of	njury - At ho etc. (Specify	me, farm, s	reet, factory, offic	е	28f.	Location (S	Street and Nur.	nber or Ri	ural Route Number,
2	ital o irs aft ral Di													
	To the Hospital or Attending Physician: The law requires tha furthe 24 hours after death. To thin 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be deleted.	edical	29a. Certifier (Check only	1 ☐ Certifying Ph 2 ☐ Medical Exan	niner: On the basis	of examinat								
	thin 2 the other mple	Med	one) 29b. Signature and	title of certifier	and manner	stated.		29c. Lice	nse number			29d. Date sigr	ned (Moni	th Day Year)
	7 × 5 8		b ()	0 × C					D 5602	.4		A		2007
,			30. Name and addr	race of narcon who	completed cause o	death (Item	23a) /Tuno							-
	1 _		Su. Name and addr	- Asbot	- 110 +(i	Istige	Loud .	Suite 110	Prince	treker.	all Mi	205 (.78	
	Sta	ite	31. Date filed (Mon	th, Day, Year)	32. Regi	strags Signa	ture	Sperk						
	Registr			AUG	3 2007▶	Bloker	w St.	Goerke	D					

			1 - For State Registrar	State of Maryland /	-	irtment of H tificate of L		•	giene Reg. No.	f to one	26591
		-	1. Decedent's Name (First, Middle, Last,)				2. Date of De			3. Time of Death
	Physici		John William Ras	lear				Month August	Day		7:55 P M
1	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of De			County of Death	7.55
	LAGIIII					Ci laron	Comina			Montgo	m o ser :
	Funeral		Arcola Health & R 5. Social Security Number 6. Se		birthday)	Silver If Under 1 Year	If Under 24 H		th	Montgoi 9. Birthp	lace (State or Foreign
	Director		114-03-4236	M 2□F	Yrs.	Months Days	Hours M	in. (Month, Da		Cour	-
			Usual Residence of Decedent	91				May_10		ro new	York
	/lanc		10a. State 10b. County	10c. City, To	wn or Lo	cation				1	0d. Inside City Limits
	Mar fied	to	Manual and Man		a.,						1 ☐ Yes 2X No
	the noti	Director	Maryland Mo: 10e. Street and Number	ntgomery	S1.	ver Spri 10f. Zip Code	ng	T	10g. Citiz	zen of What Cour	ntry?
	with sa or		321 University	Blvd, West, #3	33		20901			USA	
	leath	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.		Vas Decedent of Hi		(Specity Yes or No)-	14. Race - Americ	an Indian,
	ter c	Fun	1 Never Married 2 Married	Armed Forces? 1 TXYes 2 T No	1	f Yes, specify Cuba	ın, Mexican, Pu	(Specity Yes or No Jerto Rican, etc.)		Black, White,	etc.
36	ırsa II', ol	by	₩Widowed 4 Divorced	If Yes, Give 1945-46 Year or Dates:	1	☐Yes X XNo	Specify:			SpecWhite	
21215-0036	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examiner must be notified at	ed	15. Decedent's Edu	cation 16	a. Deced	lent's Usual Occupa	ation		16b. Kii	nd of Business/In	dustry
15	in 7	plet	(Specify only highest grad		(Give . life. E	kind of work done o OO NOT use retired	furing most of ()	working			
12	within lene. than "the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Ware	ehouse Ma	n			Furnit	ure
	be filed within 72 ho tral Hygiene. Id other than "natu event, the Medical		17. Father's Name (First, Middle, Last)				18. Mother's N	Name (First, Middle	Maiden	Surname)	
Maryland		To Be	Frank Raslear				Emma Co	nroy			
>	2 shou and M is mar	-	19a. Informant's Name/Relationship (T)	rpe. Print) 1	9b. Mailin	g Address (Street a	and Number or	Rural Route Numb	er, City o	r Town, State, Zip	Code)
Š			Thomas Raslear/ S	on 14	108 V	Woodman A	venue,	Silver S	oring	g, MD 20	902
a)	s 1 and 2 if Health item 27 i	l i	20a. Method of Disposition	20b. Place	of Dispos	sition (Name of		Date	20c. Lo	cation - City or To	own, State
٥			1 ☐ Burial 2 🖫 Cremation 3 ☐ F	removal from State		natory or other plac Ltan Crem	. P	August 3,			
Baltimore,	it. Puritme	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		*	. Name and Addres	1-	2007	Alex	kandria,	Virginia
Ba	permit. Page Department of Important; if any Injury or once.		NAK CV/	66	Fr	ancis J.	Collin	s Funeral			
1			23a. Part. Enter the disease, or complete	instinut the desired the desait. D			_			Spring	, MD 20901 Approximate
			shock, or heart failure. List only o	ne cause on each line.	o not enti	er the mode of dyin	y, such as can	alac of respiratory a	nest,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Bilateral Pne	ımoni	.a					
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):						
н	Lxammer	L.	Sequentially list conditions,	0.							
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e of):					791	
	icate be executed physician and s the burial-transit	E	that initiated events resulting in death) Last	s							
Ö,	e exi	<u> </u>	resulting in death) East	Due to (or as a consequence	e ot):						
68760,	ate b nysic he bi	edical		d							
99	ng ph	Med	IF FEMALE:								
Вох	eath certific attending p for use as f	Jue I	23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	ath 3.⊡	Ectopic pregnancy			2	23d. Date of delive	,
	dea e att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of death		Other (specify)				Month	Day Year
P.0	at the de by the tached	Physician/M	9 Unknown	3ELOIKHOWH							
ď.	The law requires that the death certif the has been signed by the attending tage 2 should be detached for use a	by P	Part II. Other significant conditions co	ntributing to death but not resulting	in the ur	nderlying cause give	en in Part I.	23e. Did	obacco u	ise contribute to t	he cause of death?
Records,	quire an sig uld b		Respiratory Fail	ure, Chronic Obs	struc	tive Pul	monary	Dis⇒se ¹□	Yes 2	No 3 Prob	pably 4 □Unknown
ပ္ပ	sw request speen	Completed	Failure To Thrive	a Dementia Cor	nfort	Care		24a. Was		24b. Were auto	psy findings available
æ	The lay	Ĕ	Tarrare 10 Intry	c) bemeneral con	ILOL (carc			ormed?	death?	mpletion of cause of
			25. Was case referred to medical	<u> </u>			OC Place of I	1 Yes Death (Check only o	2 🙀 No	1 🗆 Yes	2 No
Vital	ic ce	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpation	+ 3DDOA Othe	ar'	g Home 5 ☐ Resi		C DOther (Creek	6.1
	Phys rr this aral di	-	27. Manner of Death	28a. Date of Injury 28t	. Time of			28d. Describe			y)
o	Attending I r death. ector: After by the funer	tior	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2∐No				
<u>S</u>	Atten deat ctor y the	ica	3 Suicide 6 Could not be	28e. Place of injury - At home,	farm, stre			28f. Location (Street an	d Number or Rura	al Route Number.
Division	F 8 F C	Certification:	4 Homicide	building, etc. (Specify)				City or To			
	Hospital		29a. Certifier 1 CertifyIng Phy	sician: To the best of my knowled	lge, death	occurred at the tir	ne. date and pl	ace, and due to the	cause(s)	and manner as s	tated.
		Medical		iner: On the basis of examination and manner stated.							
	Fo the within 2 for the comple	Me	2	C A		29c. License	e number		29d. Dat	te signed (Month,	Day, Year)
	⊨≯Fŏ		11. HAMICA	monnem	/	D5	3367			ist 3, 20	
					-\ (T	7 - 1					
04) as-		30. Name and address of person who con Shyamsundar Rajan				#117	Silver S	orino	יחכ חוא .	902
4	0.		31. Date filed (Month, Day, Year)	32. Raistrar's Signature		· ····································	11-1-1	-IIVOI N	- TII6	9, 110 20.	
	Sta	ite	ALIG 0 6 2								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23a per dr. 9871 09/18/07dhb

Amend Item 23a per dr. 9873 09/18/07dhb

Amend Item 23a per dr. 9873 09/18/07dhb

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 11:40AM Louise Stoner Rider August 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Hagerstown

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 1036 Benjamin Place Washington County 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF 86 Yrs. Director 215-14-2626 March 17 1921 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Iteme 23a or 28e-f show the Modical Examiner must be notified at 1 TYes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1036 Benjamin Place 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: Š 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Rate Analyst Power Company or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fil tment of Health and Mental H tent: If Item 27 Is marked otl Russell M. Stoner Verna Giles Stoner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Importent: If Item 27 le eny Injury or other trau Sharon L. Giles - daughter 12953 Little Hayden Circle Hagerstown Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery | Aug 6 2007 Hagerstown Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home unclas 1331 Eastern Blvd. N. Hagerstown Maryland 21742 un 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresshock, or heart failure. List only one cause on such line.

Metastatic Actions. Approximate Interval Between Onset and Death Probable Cancer Metastatic Adeno Immediate Cause (Final disease or condition resulting in death) carcinomanonths 1 year **Physician** /Medical Due to (or as a consequence of Examiner Colon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included excess or injury) Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) sete hes been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2. No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No 1 Yes 2 □ No 2 No Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: Alter this certilic completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification; To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certification 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

Day, Year)

ma

person who co eled cause of death (Item 23a) (Type, Print)

				ate of Maryland	d / Depa		Health and N	lental Hygie	_	ole.	25.92
	Physic		1. Decedent's Name (First, Middle, Last) Gerold Bru	ino Scho	fer			2. Date of Death Month	Day 11 20	Year	3. Time of Death 9:10 A M
0	/Medi Exami		4a. Facility Name (If not institution, give street	and number)	7101	4b. City, Town, o	or Location of Death	August	4c. County		19:10 A
	Funeval		Calvert Memorial Ho 5. Social Security Number 6. Sex	spital 7. Age (In yrs. In	ast birthday)	Prince If Under 1 Year	Frederic	8. Date of Birth	Cal	vert	laco (State or Ferrina
	Funeral Director		578-02-5726 ¹™ ²		Yrs.	Months Days	Hours Min.	(Month, Day, Y 02–12–19		Czec	lace (State or Foreign try) hoslovakia
	yland yland at		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	he Mar 28a-f sh otified	Director	MD Anne Arund	lel			Landing				1 □Yes 2 No
	3a or		10e. Street and Number 282 Fairhaven Road			10f. Zip Code	0779	10g	. Citizen of W USA		itry?
	r death	Funeral	11. Marital Status 12. W	as Decedent Ever in U.S	S. 13. V		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race		an Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 Never Married 2 Married 1	∏Yes 2∏XNo Yes, Give ear or Dates:		☐ Yes 2X No	Specify:	Thours, etc.,	Specify:	whi	
Maryland 21215-0036	72 ho "natur dical E	Completed	15. Decedent's Education (Specify only highest grade com	pleted)	16a. Deced	ent's Usual Occup	pation during most of work d)	ing	b. Kind of Bus		
2121	I within jiene.	dmo	Elementary/Secondary (0-12)	ollege (1-4or 5+) 5+			ice attori		nterna	tion	al law
nd	tal Hyg	Be C	17. Father's Name (First, Middle, Last)		1	practi	18. Mother's Name	e (First, Middle, Ma			ar raw
ryla	hould to d Meni marked matic e	은	Alois Schofe 19a. Informant's Name/Relationship (Type. Pr	_	405 14-11-	- Address (0)	Olga	Frey			
	ind 2 sl alth an 27 is r ir traur		Gianfranca Schofer		1			al Route Number, C acy's Lan			
Baltimore,	ges 1 a of Hei or othe		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Remove	20b. Place		sition (Name of natory or other place	•		c. Location - (
Ħ.	it. Pag rtment rtant: njury e		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Met			atory 8-1		Alexano		
Ba	permi Depar Impor any Ir		William R	Gro		Name and Addre	100	usch Fund ne, Owing			
0	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	ongesti	Do not ente		ng, such as cardiac				Approximate Interval Between Onset and Death
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No	executed n and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Oue to (or as a consequently percently percent	asion						1990
ς 68760,	eath certificate be executed attending physician and for use as the burial-transit	- E	d								
.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	res, outcome pf pregnan □Live birth 2 □ Fetal □Pregnant at time of de □Unknown	death 3□	Ectopic pregnancy Other (specify)			23d. Date Mon		ry Day Year
<u>s</u> , Р	res tha igned l be det	ò	Part II. Other significant conditions contribution	ng to death but not resul	ting in the un	derlying cause give	en in Part I.				e cause of death?
Sorc	w requir been si should	eted		-				-	2 □ No :	3 Proba	ably 4 Unknown
Division or Vital Records, P.O.	an: The lav ificate has or, page 2:	Completed	25. Was case referred to medical					24a. Was an autopsy performed	i? pr	ere autor for to con eath? □Yes	osy findings available npletion of cause of
Z	nding Physiclan: th. : After this certifica ; funeral director, I	To Be	examiner? 1 ☐ Yes 2X No Hospita	l: 1 ☐ Inpatient 2 💢 E	R/Outpatient	3 □ DOA Othe		n <i>(Check only one)</i> me 5 ☐ Residenc	e 6 □Othe	r (Specify	·)
o uc	ding P. After t		1 Natural 5 Pending	Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	y at :	28d. Describe how			· · · · · · · · · · · · · · · · · · ·
Division	ial or Attends after death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e	. Place of injury - At hon building, etc. (Specify)			Yes 2□No	28f. Location (Stree City or Town, S		r or Rural	Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	ledical		To the best of my know n the basis of examination d manner stated.	ledge, death on and/or inve	estigation, in my o	pinion, death occurr	and due to the caus red at the time, date	e(s) and man and place, a	ner as stand	ated. the cause(s)
	vit To	2	29b. Signature and title of certifier	M	. M	29c. License		29d.	Date signed	(Month, I	Oay, Year)
	.6	-	10. Name and address of person who complete		on Mo 23a) (Type, P		16242		0//7	12	00/
	1 7		E. Thomas Manion, M.I	0., 900 Bes	tgate		. 303, An	napolis,	MD 214	101	
	Sta Registr			2. Registrar's Signatu	ire (1704)						

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day 2007 **Physician** 4:00 AM M August 1, Martha Ann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Charlotte na i | Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) Oct. 3, 19 Charlotte Hall Charlotte Hall Veterans' Come Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🗓 F 1922 Ohio 84 001-20-8605 Director Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other then "naturel", or Iteme 23a or 28e-1 ehow other traumatic event, the Mardical Examiner must be required at 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 XNo **Funeral Director** Waldorf Maryland Charles 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20601 2797 Desert Sun Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: White Be Completed by 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leona Lands Russell Hoylman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 50 Post Office Rd., Suite 302, Waldorf, MD 20601 Frank L. Sams, Jr. - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Peges 1 nent of H ant: If Ite ury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Depertment of Important: if eny Injury or pace. Trinity Memorial Gdns8-4-2007 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 3035 Old Washington Rd. 21. Signature of Funeral Service Licensee M01246 Waldorf, MD 20601 Huntt Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** covonaru /Medical Examiner potu aconsequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit vascular disease P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 1 No or Attending Physicien: To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: A□ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 Yes 2 DAG 3□ DOA 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 27. Manner of Death Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier and eath (Item 23a) (Type, Print) address of person who completed 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State AUG 0 2 2007 Registrar

07-06090 Chyrl Shen Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

yrı s	sneparu			r State	Stat	e oi iviai	yland /	Certi	ficate of	Death				Reg. No.			(0
	Physicia	an/	1. De	ecedent's Name (F	irst, Middle,I	ast)							Date of De Month August 8	Day	Year	1	3. Time of Death 1615 hrs
. 40	' Exami	ner		7	_		-d sumbor\		14	b. City, Town, or	Location of		August o		County of	Death	
				acility Name (if no 430 Gilmor St		give street ar	ia number)		"	Baltimore							
	Funeral			ocial Security Num		. Sex	7. Age	(In yrs. las	t birthday)	If Under 1 Yea			8. Date of E	Birth (MM/D	D/YYYY)	Loreign	place (State or
	Funeral Director			15-66-01		1 M 2 3	₫F 49		Yrs.	Months Day	Hours.	Min.	May	4, 19		Coul	ntry) MD
				al Residence of D													10d. Inside City Limits
	any		10a.	. State 10	b. County		1	-	own or Location	on							1 X Yes 2 No
	and show	٥]	MD				Bal	timore	10f, Zip Code			•	10g Citiz	zen of Wh	at Coun	
	Maryl 28a-f d at o	Director	10e.	Street and Numb						21223				USA			•
5	death with the Maryland or items 23a or 28a-f show must be notified at once.				1 50.	40.1846	s Decedent E	ver in II S	13 Wa	s Decedent of H	ispanic Orig	in? (Spe	cify Yes or I	_	14. Race		can Indian, Black,
	tems	Funeral	11.1	Marital Status Never Married	2 Mar	ried Arn	ned Forces?		If Y	es, specify Cuba	ın, Mexican,	Puerto F	Rican, etc.)		White	, etc.	
	ter dez	교		Widowed	4 XDivo	rced If Yes, G	ve Year	X No		Yes 2 X N			<u> </u>		Specify:		
	urs af Horal	à	15	5. Decedent's Edu	cation (Speci	fy only highe	st grade com		16a. Deceden	t's Usual Occup ost of working lif	ation (Give k e. DO NOT	cind of we	ork done ed)	16b. K	Kind of Bu	siness/li	ndustry
,	72 ho nn "ns cal Ex	Completed	E	Elementary/Second	dary (0-12)	Coll	ege (1-4 or 5	+)	N/A						Disa	ble	đ
Š	within iene.	E	:	10 Father's Name (F	Total Malada	Lost\					18.Mother	's Name	(First, Middl	e, Maiden			
1	filed filed Il Hyg ed oth	٥	וט		rd Dur						Darl	ene	Bosle	v She	epard	1	
3	MID 21219-1050 2 should be filed within 72 hours after death with the Maryland h and Menal Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho zry is marked other than "natural", or items the notified at once, mustic event, the Medical Examiner must be notified at once.	E	19a	a. Informant's Nam	ne/Relationsh	ip (Type, Prir	nt)		19b. Mailin	g Address (Str	eet and Nun	nber or R	ural Route I	Number, C	city or Tow	n, State	, Zip Code)
9	e, IMID 212.13-0030 I and 2 should be filed within 72 hours after Health and Mental Hygiene Firen 27 is marked other than "matural", ir Irranmatic event, the Medical Examiner.	Ι.	J	ason E.	Shepar	<u>d</u>	SO	n	39 Sa	ra Lane	Har	ove	Date	173.	31 Location	- City or	Town, State
	ore, is and of Heal		20a	a. Method of Dispo		3 Rem	oval from Sta		rematory or of	her place)		0.15			ampst		
	MOFE Pages 1 nent of F amt: If i		4	Donation 5	Other Sp	ecify:		Car		remation							
	Baltimore, permit. Pages I ar Department of Her Important: If ite		21.	. Signature of Fun	eral Service	Licensee			22.1	Name and Addre	ess of Facilit	Prid	tts Fu	inera.	T Hou	ne & ⁄n	Chapel, PA
	(i)	_	23	a. Part I. Enter the	e disease, or	complications	that caused	the death.	Do not enter	2 Wash1 the mode of dyir	ng EON ig, such as o	cardiac o	r respiratory	arrest, sh	ock, or he	art	Approximate Interval Between Onset and
1	hysiciar ledica		ì	failure. List only	y one cause	Mr.	d drug ((morph	ine and	trazodone) intox	icati	on.				Death
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	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been simed by the attending physician and To the Funeral Director: After this certificate has been simed by the attending physician and	in a	ᅙᆝ	X UNPENDED		#	23a,27,			370 , 8/20/	07 TT_			2	3d. Date o	of delive	ry
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	of V g Phy frer th	neral	2	7. Manner of Dear		2	8a. Date of In (Month, Dey	jury ,Yeer)	28b. Time o		Injury at Wo		28d. Desc	cribe how i	injury occi	urred	
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	Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	completely filled in by the funeral director, page 2 should	ical	29a. Certifier 1 (Check only one) 2		aminer: On th	ne basis of ex	kamination	and/or investi	gation, in my op	inion, death	occurred	at the time	, date and	place, an	d due to	the cause(s)
	To t	com	Medical	29b. Signature and	A	/ and	manner state	d.,			cense numb			29	d. Date si	igned (/	Month, Day, Year)
	_		- -	0/1	1//	In		1.		C	.C.M.E.			A	vugust 9	, 2007	7
7	MIL		7	30. Name and add	ress of perso	n who compl	eved cause o	f death (Ite	em 23a)								
	0		l s	Susan Hog		Assistan	Medical	Examine	er 111 P	enn Street,	Baltimore	e, MD 2	1201				
		St	ate 3	31. Date filed (Mor		r)	32. legis	trar's Signa	ature								
	Reg	gist	rar	A	UG 1 4	2007	Plas	m,	o s	out -	· · · ·						
г	HMH 17 Rev	/ 1/20	001						ORIGI	NAL						OCM	E

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) ALL 11 2007 ear Physician ANNIE MAE SELF 8.35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE HOSPITAL CENTER GEORGE CHEVERLY MARYLAND PRINCE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 17 1916 9. Birthplace (State Toreign **Funeral** Months Days Min Hours 91 WESTMORELAND, VA 228-18-1703 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits ahow r than "natural", or itema 23a or 28a-f ahov the Medical Examiner must be notified at Yes 2 No MD. P.GEORGE, COUNTY MITCHELL VILLE, MD. Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3607 BURLEIGH DRIVE 20721 U.S.A 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes No If Yes, Give Year or Dates: 1 Never Married Married Baltimore. Maryland 21215-0036 1 Tes 2 No Specify: AFRO. AMERICAN à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 8th.Grade 55. Decedent's Education only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th, Grade CAFETERIA WORKER THE PENTAGON other permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Importent: if Item 27 is marked othe any injury or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN HICKMAN MARTHA ELLA JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLAUDIA PAYNE 3607 BURLEIGH DRIVE MITCHILLEVILLE MD. 20721 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 8-18-2007 MONTROSS, VA. 22520 4 ☐ Donation 5 ☐ Other (Specify) GRANTS HILLHURCH 21. Signature of Funeral Service Licensee CCO 240 22. Name and Address of Facility 12055 JAMES MADISON PKWY.KING GEORGE, VA. 22485 ugene e 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or right failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death DEMENTIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Peri Pherel vosular obsesse if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner 5 days attending physician and for use as the burial-transit requires that the death certificate be executed 64 Com resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🔀 No the 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 1 Yes 2 No 1 ☐ Yes 2 □ No Division of Vital the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 KNo 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) l in by 4 Homicide 29a, Certifie 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mukemil 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar Alig 1 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Schuitema Month Alan 11:08 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Johns Hopkins Hosp.1 N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/22/1952 Birthplace (State or Foreign Country)
 MI 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 □ F 385-56-5340 Director 55 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov notified at 1 ☐ Yes 2 No Director Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be 20639 4132 Birch Drive U.S.A death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specify: White 3 Widowed 4 Divorced "netural" Completed item 27 Is marked other than "netu other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer Comunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Donna Jean Bulson Donald Schuitema 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Schuitema/Wife 4132 Birch Dr. Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08/02/2007 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans 22. Name and Address of Facility Lee Funeral Home Calvert, P.A 21. Signature of Funeral Service Licensee Gary J. Goff 8125 Southern MD Blvd. Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** embol day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner endocard Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off-Examiner Metastic ettending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an ate has bage 2 s autopsy performed? Yes 2 No 1□ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 🙇 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours a To the Funerel I

> 20 State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Voctor

Medical

2007

Itapkins Hospital 32. Registra Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

600 North Wolfe Street Baltimore

29d, Date signed (Month, Day, Year)

			Registrar				Cer	titicate	of L)eath	7		Reg. No.			
	n.			e (First, Middle, La	ist)	0						2. Date of D Month		Year	3, Time o	f Death
	Physic /Medi		Н	amed		Sarum	1					July	31, Day 2	007	4:55	РМ
	Examir		4a. Facility Name (i Washin	lf not institution, given good and gton Ad	vestreet and numb	Hosp	ital	4b. City, To	wn, or	Location ma P	of Death		4c. Co Mo	ntgo	mery	
7	Funeral Director		5. Social Security N 214-82-		Gex 7	. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months [Year Days	If Under Hours	Min.	8. Date of B	irth Year) 2 6 , 195	9. Birt	hplace (State ountry) Nigeri	or Foreign
	D		Usual Residence o													
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	h with th	Funeral Director	10e. Street and Nu 3924	17th S	t.			10f. Zip C	ode 1071	32			Nige		untry?	
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5-0	72 ho	Completed by	(Spec	15. Decedent's E	ducation		16a. Decede (Give k life. D	ent's Usual (Occupa done d	ition	st of works	na	16b. Kind	of Business/	Industry	
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Baltimore,	Depentit. Depentit Importational		21. Signature of Fu	uneral Service Lice	Lewell		1 4 S	Name and a	Addres	s of Facili	ach	ewell Rd. I	Funer	al H	ome	10678
1			23a. Part1. Enter t	he disease, or com art failure. List only	plications that cau	used the death	n. Do not ente	the mode	of dying	g, such as	cardiac o	r respiratory	arrest,	- 1	Approxima Interval Bel	le
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	/Medical		resulting in death)	•	aDue to (or	ras a consequ	clevo uence of):	96		101	0 0 4 1	CAR	1 24/1			
18	Examiner		Conventially list on	aditions	, C	hone	c 12	ens	1	La	ilw	e				
	D =	ner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events	nmediate erlying	Due to (or	ras a consequ	ience of):									
	acute ind trans	am	Cause (Disease or that initiated events resulting in death) I	injurý	c		p513	5								
ő,	e exe	Ě	resulting at death)	LdS(Due to (or	as a consequ	ience of):									
68760,	cate b	dica		•	d											
Box	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months?		h 2 Fetal nt at time of de	death 3 1	Ectopic preg Other (spec	nancy				23d.	Date of deli	,	Year
P.0	thet the		Part II. Other signif		contributing to dea	th but not resu	ulting in the una	teriving cau	se nive	n in Part I		23e Did	tobacco use	contribute to	the cause of o	leath?
of Vital Records,	sign d be	d by			•		,	,,,,,,	gc				Yes 2□N		obably 4 🔀	
Ö	w requir been si should	Completed										24- 146				
Re	The lay	ם		-								24a. Wa aut	opsy formed?	prior to death?	topsy findings completion of c	available ause of
a	ician: Th certificate rector, pag	CO	25. Was case refer	red to medical								1 Tes	2.⊠No		2 No	
Ē	ysician: is certific director,	To B	examiner?		Hospital:	ationt 2 🖂 G	ER/Outpatient	2C3 DOA	Othe	_		(Check only		0.1. (0.		
o	ding Phy h. After this funeral c		27. Manner of Deat		28a. Date of (Month,		28b. Time of		. Injury Work	4 🗀 NI			how injury of		city)	
ion	nding ath. r: Afte	atio	1 Natural 2 Accident	5 Pending investigation		Day Year)	Injury	м		? ′es 2 🔲	No					
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 4 Homicide	6 Could not b determined	28e. Place of	f Injury - At hor , etc. (Specify	me, farm, stre	et, factory, o	ffice		2	28f Location City or To	(Street and No	ımber or Ru	iral Route Num	nber,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one)		nysician: To the b niner: On the bas and manne											;)
	To the within To the comple	Me	29b. Signature and	title of certifier	completed cause Ait MC 32. Reg 6 2007			29c. L	icense	number	- / :		29d. Date si	gned (Monti	n, Day, Year)	
			14	1, / '	5-P			-++	1)(006	0100		00-	0 /		
	5		30. Name and addr	ess of person who	Ait ME	of death (Item	23a) (Type, P	rint)	131	,0	nise	131 hg	ISLI	d &	ast	
4.	Sta	te	31. Date filed (Mon.	th, Day, Year)	32. Rec	jistra Signat	ure	ho ?	-7	-	Sil	1 - N	hand	MD	20 9	c S
	Registr			AUG	6 2007	Berleve.	1 15.	GOSM	L.							
DIA	MI 147 Day 140	201						1								

	•	For State Registrar			tificate of L	ealth and M Death		g. No.	
Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month JULY	n 30 200 ⁷ 7	3. Time of Death
/Medic		GREGORY STEV			# C' T	Lastin (Dark	JOHI	4c. County of De	
Examin		4a. Facility Name (If not institution, give si FT. WASHINGTON	HOSPITAL		FT. WAS	Location of Death	,	PRINCI	E GEORGES
Funeral Director		3/3 00 2131 -	7. Age (In yrs. I	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10/2//	Year) WA	Birthplace (State or Fore Country) SHINGTON ,
* 1		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Lim
is she	គ្ន	MD PRINCE O	GEORGES F'	T. WA	SHINGTO	N			1. Yes 2□
7.28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
23a o		13308 PENDLETON	J ST.		207	4 4		U.S.A	
and Mental Hyglene. is marked other than "natural", or Items 23a or 28a-1 show aumatic svent, It's Modical Examiner must be notified at	Funeral	11. Marital Status 1 1 □ Never Married 2 ▼Married 1	2. Was Decedent Ever in U. Armed Forces? 1 ☐Yes 2∑No If Yes, Give		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2000	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	•
E	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					Specify: B	
natu Ilica	Completed	15. Decedent's Educ (Specify only highest grade		(Give	tent's Usual Occupa kind of work done of DO NOT use retired	during most of work		16b. Kind of Busine	ss/industry OF PUBLIC
Fig.	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		R SERVI		ECTOR	WOR	
Hyge ont, #		17. Father's Name (First, Middle, Last)				18. Mother's Nam			
Mental ? larked of latic sve	o Be	CHARLES STEVEN	1S			TEMP:	IE WEAV	ER	
mari mari	၉	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailir	ng Address (Street a	and Number or Rur	al Route Number	, City or Town, State	e, Zip Code)
= 2 = 1			ENS/WIFE	1330	8 PENDL	ETON ST	. FT. W	ASHINGT	ON, 20744
item 27		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other plac			20c. Location - City	or Town, State
		¹X urial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	emoval from State MT	. ÓLI	VET CEM	. 8/3,		WASHING	
Department of Important: If any injury or once.		21. Signature of Funeral Service License	10	22	2. Name and Addres	ss of Facility S	TRICKLA	ND FUNE	RAL SERV
		Kennodi	. Stowart	6	500 ALL	ENTOWN	RD. CAN	MP SPRIN	GS, MD 2
		23a. Part1. Enter the sease, or composhock, or heart sture. List on you	cations that caused the death	h. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
ysician		Immediate Cause (Final disease or condition	ATHEROSCL						Onset and Deat
Medical		resulting in death)	Due to (or as a consequ		Se Seite II.	- W-30-U1	17 17 10 E	4406	
aminer		Sequentially list conditions	LUNG CANC						2 YEARS
- 	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dearto (or as a sonsequ	uanea ut):					
and -tran	Kam	that initiated events cresulting in death) Last	Due to (or as a conseq	neuce ot):					
ohysician and the burial-transit	a E								
	dical	0							
ed by the attending p detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	I death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
by the	hys	9 🗆 Unknown	9 Unknown						
6.8	d by P	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.			e to the cause of death] Probably 4 ∐Unkn
as been si 2 should l	Completed						24a. Was a		autopsy findings avail to completion of cause
age 2	E						autops perfor	med? deatl	h? Yes 2□ No
. S. C.	BeC	25. Was case referred to medical				26. Place of Dea	th (Check only or		
£ 5	To B	examiner? 1 Tes 2 No	lospital: 1 🔀 Inpatient 2 🗆	ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing He	ome 5 🗆 Resid	ence 6 🗆 Other (5	Specify)
is certif directo		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	y at k? Yes 2 □ No	28d. Describe h	ow injury occurred	
uth. r: After this certific e funeral director,		14∑Natural 5 ☐ Pending 2 ☐ Accident investigation		ome farm st	reet, factory, office		28f. Location (S City or Tow	treet and Number o n, State)	r Rural Route Number,
after death. Director: After this certif I in by the funeral directo			28e. Place of Injury - At he building, etc. (Specif						
24 hours after death. • Funeral Director: After this certif etely filled in by the funeral directo	Certification;	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined		y) wiedge, deat	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occur	, and due to the corred at the time, co	ause(s) and manne late and place, and	r as stated. due to the cause(s)
within 24 hours after death. • the Funeral Director: After this certif ompletely filled in by the funeral directo		2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only Medical Examin	building, etc. (Specification) sicien: To the best of my knowner: On the basis of examina	y) wiedge, deat	h occurred at the tirvestigation, in my o	pinion, death occu	rred at the time, o	ause(s) and manne late and place, and 29d. Date signed (M	due to the cause(s)
within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical Certification;	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) Caption investigation 6 Could not be determined	building, etc. (Specification) sicien: To the best of my knowner: On the basis of examina	y) wiedge, deat	vestigation, in my o	pinion, death occur e number	rred at the time, o	late and place, and	due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7-31-07 ay Physician 10:55 PM SMITH CLAUDIA Ε. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner MONTGOMERY OLNEY MONTGOMERY GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Y13 **Funeral** Days Months Hours Min. 1 ☐ M 2 🖫 F 82 227-30-2166 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director MONTGOMERY TAKOMA PARK MD 10f. Zip Code 20712 10e. Street and Number 10g. Citizen of What Country? 7620 MAPLE AVE. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 🏖 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) PX EXCHANGE 8TH GRADE STORE MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BROWN NANCY HENRY U. LUCAS ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TER JACQUELINE S. TURNER-DAUGH 4603 WINDING STONE CIRCLE OLNEY, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CHELTENHAM VET. 8 - 7 - 07CHELTENHAM, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. 524 - 8TH ST., N. E. 20002 WASH., DC 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. of enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonari **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 4 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) motamed 0 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month AUG U



andra Candice Thompson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 3, 2007 0330 hrs **Medical Examiner** andra Candace 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Cecil 3341 Telegragh Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex **Funeral** Foreign Country) Zimbabwe Min Months Hours 03/03/1982 Director 199-70-4565 1 M 2 X F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Oxford 1 X Yes 2 No Chester permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country' 10e. Street and Number 10f. Zip Code 9363 USA 205 Delaware Ave Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married Married Yes Specify: Black Yes 2 X No specify: If Yes, Give Year 3 Widowed Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Education leacher MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rooven June Van Colin L. Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, tate, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Oxford, PA Delaware Ave Thompson Colin 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State 8-10-2007 Leola, vans Crematory Donation 5 Other Specify: 22. Name and Address of acility

Livery Collins Funeral Home

8.6 Fine 5t. Oxford, AA 193 21. Signature of Funeral Service Ligensee Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Death Head and thermal injuries and smoke inhalation Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Hospital or Attending Physician; The law requires that the death certificate be executed Physician/Medical #23a,27,28a-f, perME,g870, 8/22/07 TT X UNPENDED signed by the attending physician be detached for use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available certificate has been autopsy prior to completion of cause of performed? death? 1 ✔ Yes 2 Νo No 1 🗸 Yes 26.Place of Death (Check only one) uneral director, 25. Was case referred to medical å Hospital: 1 Other4 Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 this 1 Yes No 28a, Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification Driver of auto/fixed objects impact 1 Natural 1 Yes 2 X No within 24 hours after death.

To the Funeral Director:
completely filled in by the f Pending vith auto catching on fire

28f. Location (Street and Number or Rural Route Number, City 8/3/2007 3:30 am 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)
3341 Telegraph Rd, Elkton, MD 3 Could not be Suicide determined (Specify) field 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number August 3, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) OCME

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Mary G. Ripple MD.

31. Date filed (Month, Day, Year)

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Deputy Chief Medical Examiner

32. Registrar's Signature

			1 - For State Registrar	State of Marylan		rtificate of		, 0	eg. No. 2 1 7	26601
П	Physici	an	Decedent's Name (First, Middle, La. KENNETH MER	•				2. Date of Dea Month	Day Year	3. Time of Death 5:30 P M
	/Medic	2	KENNETH MER 4a. Facility Name (If not institution, give		<u>.</u>	4b. City, Town,	or Location of Death		01 , 2007 4c. County of Deat	
	Examin	ei	, ,	SING HOME		RANDAI	LISTOWN		BALTIMORE	COUNTY
	Funeral Director		537-14-1506	ex	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. Birt 1926 ST • .	hplace (State or Foreign untry) JOHN, WASH.
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c, City	y, Town or Lo	ocation				10d. Inside City Limits
	a-f sh	ctor	DE SUSSEX	DA	GSBOR)	a			1 ☐ Yes 2 🗶 No
	or 28 be not	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	eath v ns 23a must	Funeral Director	29915 MOUNTAIN L	AUREL DRIVE 12. Was Decedent Ever in U.	S. 13.	19939 Was Decedent of		pecify Yes or No-	14. Race - Ame	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	출	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ★Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puert Specify:	o Rićan, etc.)	Black, Whit	e, etc.
5	"natu	etec	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occu	pation e during most of wor ed)	king	16b, Kind of Business/	Industry
121	within ene. than he Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			EVELOPER		REAL ESTA	TE
	e filed Il Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last				18. Mother's Nan	ne (First, Middle,	Maiden Surname)	
ylar	ould be Menta arked atic ev	ToE	PETER LEWIS	TAYLOR					TH CALVERT	
Maryland	12 sho hand 7 Is ma traum		19a, Informant's Name/Relationship (Type. Print) DAUGHTER		•			r, City or Town, State, 2	
	s 1 and F Healt tem 2 other		20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of matory or other pla		Date DAG	20c. Location - City or	
<u>o</u> E	Pages nent of nt: If I		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	JRemoval from State	•		ETERY AUG	6,2007	MILLSBORO	• DE
Baltimore,	permit. Departn Importa any Inju		21. Signature of Funeral Service Incer		2: W	2. Name and Addr		E P.O.	BOX 125	
۴	6		23a. Part1. Enter the disease, or com shock, or heart failure. List only			ter the mode of dy	ing, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
e l	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence		-1				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of)	8				
h	To Sales	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a conseq	uence of):					_
	tificate be executed ig physician and as the burial-transit	Examiner	that initiated events	C						
60,	tificate be executed ig physician and as the burial-transit		resulting in death) Last	Due to (or as a consequent	uence of):					
68760,	ficate I physi s the k	edical		d						
P.O. Box (The law requires that the death certi tte has been signed by the attending age 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	⊒Ectopic pregnan ⊒ Other <i>(specify)</i>	су		23d. Date of de Month	livery Day Y ear
٠ <u>;</u>	s that t ned by e detac	by Ph	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause g	iven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ords	equire en sig ould be	ed b						1 🗆 Y	es 2 No 3 P	robably 4 MRnown
Seco	e law r has be le 2 sh	Completed						24a. Was a autop	sy prior to	utopsy findings available completion of cause of
a H	The licate l							perfor 1□ Yes	2 ☐ 1 ☐ Yes	s 2□ No
Ĭ,	s certifirecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	FR/Outpatie	nt 3 DOA	thor.	ath <i>(Check only or</i>	ne) ence 6 ∐Other <i>(Spe</i>	ocify)
0	ig Phy ter this neral c	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				ow injury occurred	Oily
sior	Attending Physician: r death. ector: After this certifice by the funeral director,	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	n		M 1[Yes 2 No			
Division or Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	4 ☐ Hornicide determined	building, etc. (Specif	y) 			City or Tow		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical		nysician: To the best of my kno miner: On the basis of examina and manner stated.						
	To the le within 2. To the I complet	Σ	29b. Signature and title of certifier Runner Ma	Vir mo			rise number	1	29d. Date signed (<i>Mon</i>	th, Day, Year)
4	3A3+1		30. Name and address of person who	completed cause of death (Iten	n 23a) (Type,	Print)	0	1		
L	Sta	ate.	31. Date filed (Month, Day, Year)	25 Mari Strug 32. Registrar's Signa 2007	ature	20.	16m Jeston	Mp	21136	
K	Regist		AUG 0 6 2	2007	B 4	berli				
DL		001			7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State Registrar

DHMH 17 Rev 1/2001

30. Name and address pers

31. Date filed (Month, Day, Year

e of death (Item 23a) (Type, Print)

32. Registrar's Signature

07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryla		rtificate o		iu Mentai ny	Reg. No.	100	6.0000
	D1		1. Decedent's Name (First, Middle, Las)				2. Date of D Month	eath Day	Yeer	3. Time ol Death
	Physici /Medic			ompson				07	29	2007	11:20 AM
	Examin	er	4a. Facility Name (If not institution, give	-			n, or Location of D	Death		nty ol Death	1
			5. Social Security Number 6. Se	Cerm Ln	rs. last birthday)	Il Under 1 Ye	ar If Under 24	Hrs. 8 Date of Bi		-ecil	lace (State or Foreign
ı	Funeral Director		403-72-8442	M 2₽F 55	Yrs.	Months Day		Hrs. 8. Date of Bi (Month, D			place (State or Foreign of try)
	and and		Usual Residence of Decedent 10a, State 10b, County	10c.	City, Town or Lo	cation				1	0d. Inside City Limits
	Mary I-f eh	tor	AZ Pima		Tucson						1 XYes 2 No
	with the	Funeral Director	10e. Street and Number 1600 N. Welmont	ve # 166		10f. Zip Code	e 712			of What Cour	ntry?
	me 23	nera	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent	of Hispanic Origin	? (Specify Yes or N Puerto Rican, etc.)	o- 14. F	Race - Americ	
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iteme 23e or 28e-f ehow important: If item 27 is marked other than "natural", or iteme 23e or 28e-f ehow artificially injury or other traumatic event, the Medical Examinational Contest and Item and Dance.	by	1 Never Married 2 Married 3 Widowed 4 Morried	1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates:		il Yes, specily C		ruento riican, etc.)	1	Black, White, ocity: Whi	
5 O	72 ho	eted	15. Decedent's Ed (Specify only highest grad		16a. Deced	dent's Usual Oci	cupation ne durina most of	f working	16b. Kind o	f Business/In	dustry
7	Mithin ne. han	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use rei Homemak	ne during most of tired)			Homema	ker
D	filed v Hygie ther I		17. Father's Name (First, Middle, Last)					Name (First, Middle	1		
<u>a</u>	Mental Mental arked o	To Be	Victor H. Thomps	son			Nov	a Ridner			
ary	2 should and Men Is marke sumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Stre		or Rural Route Numi	er, City or To	wn, State, Zip	Code)
	end 2 ealth n 27 I		Sheryl Grant				ridge Fa		larwick		21912
Baltimore,	permit. Pages 1 end Department of Health Important: If itam 27 eny injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	-	natory or other p	olace)	Date		on - City or To	
₫	it. Pa intmen intent: injury		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service License	101	nesapeak			3/2/2007			
Ba	permit. Departi Importi eny inj		> Buk of	lefferen		130 Spe	er Rd. C	Fellows, Chestertov	m, MD	21620	
			23a. Part1. Enter the disease, or config shock, or heert lailure. List only	lications that caused the do ne cause on each line.	eath. Do not ent	er the mode of o	dying, such as car	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
j.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons	whire	Tura	tall	LURE			
Н	Examiner			Ango	sequence of):	2-DO I	1 eres	DIFFAL	·P		10 years
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a cons	sequence of):	0.70	0-1001	<u> </u>			, ,
	and transi	ami	Cause (Disease or injury that initiated events resulting in death) Last	с							
60,	ificate be executed g physicien and as the burial-transit	edical Examiner		Due to (or as a cons	sequence or):						
68760,	ficate physis the	adic	`	d							
	h certi	-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		Tetopia progna			23d.	Date of delive	ery
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Completed by Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of		Ectopic pregna Other (specify,				Month	Day Year
	that the that the the the the the the the the the th	y Ph	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause	given in Part I.	23e. Did	tobacco use c	ontribute to the	he cause of death?
rds	w requires t been signe should be	ed b	COLON	Cancer				15	Yes 2□No	o 3□Prot	pably 4 ∐Unknown
900	e law re has bee je 2 sho	piet	EMPHYS	RMA				24a. Wa	s an 24	b. Were auto	psy lindings available mpletion of cause of
Ě	The yate his	Com						pert	ormed? 2 ☑ No	death? 1 ☐ Yes	
Vita	ician: Sertific ector.	Be	25. Was case referred to medical examiner?	Hospital:				Death (Check only	one)	icer's	
of	Phys this ral dir	5	1 Yes 2 No 27. Manner ol Death	1 inpatient 2	ER/Outpatier 28b. Time of	1 3 DOA		ng Home 5 TRes	how injury oc		ý)
O	Attending Physician: r death. sctor: After this certifice by the funeral director.	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year,) Injury		njuryat Work? I∐Yes 2∐No		now injury ou	ouno a	
Division of Vital Records,	or Atter after dea Olrector in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, larm, str ecify)	eet, factory, offi	СВ		(Street and Nu own, State)	ımber or Rura	al Route Number,
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Co	Check only one)	nician: To the best of my liner: On the basis of exam and manner stated.	rnowledge deal! ination and/or in	vestigation, in m	a time, data and p ny opinion, death o	Stace, and due to the occurred at the time	cauca(c) and , date and plac	manner as e ce, and due to	(ated o the cause(s)
	Fo the within Fo the	Me	29b. Signature and tille of certifier	and married stated.		I	ense number		29d. Date sig	gned (Month,	Day, Year)
	->-0		 			· Ī	05651		7	290	1
	5		30. Name and address of person who d	mpteted cause of death (I	4 . 4 . 4	Print)			1 000	,	
	EN-		PRICE JORGH	Marin MD	106	Bung	51 -	EKRO	, W)	4
	Sta	te	31. Date filed (Month, Pay Kear) 1	2007 32. Resistrar's Sig	gnature	Should a					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Day **Physician** 10:26 a_M August 2, 2007 Usenica /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery 2313 Ring Street
5. Social Security Number 6. Se If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1∰M 2□F Months Director 213 44 3592 September 5, 1923 Croatia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other then "naturel", or items 23a or 28a-1 show other traumatic event, it a Modical Examiner must be notified at XX Yes 2 ☐ No Maryland Montgomery Director Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2313 Ring Street 20851 death 1 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after ☐Yes 2½ No Yes Give 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 20X No Specify: Specify: White à If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Automotive es 1 and 2 should be filed w of Health and Mental Hygier If item 27 Is marked other tl Auto Body Technician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Luis Usenica ပ Rosalija Horbat 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2313 Ring Street, Pockville, MD 20051 ca of Disposition (Name of Date Fmilia Ana Usenica/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 nent of H ant: If ite 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Entombrent Gate of Heaven Cemetery August 6,2007 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. of Facility 21. Signature of Funeral Service Licensee KenSlik 500 University Boulevard West, Silver Spring, MD 20901 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Congestive Heart Failure /Medical Due to (or as a consequence of): **Examiner** Dilated Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a colisequence of). The law requires that the death certificate be executed attending physicien and for use as the burial-transit Atrial Fibrillation Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2√2 No 3 Probably 4 Unknown Completed Chronic Obstructive Lung Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2√☐ No Hospitel or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home sidence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No in 24 hours ofter deam. the Funerel Director: After this relately filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 2, 2007 D-19400 Po 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print) 0)

State

31. Date filed (Month, Day, Year) AUG 0 6 Registrar

32. Pagistrar's Signature

Doctor Erresto Africano, M.D.344 University Blvd West, #22, Silver Spring, MD 20901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene.

			1 - State of Maryland / Department of Certificate of Certificate Certifica		lental Hygiei Reg.	2001	26605
	Dhuaisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Selma M. Weeks		July 26		1:47 A M
k	Examin			or Location of Death		4c. County of Death	
				ce Frederi		Calvert (
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 K F 7. Age (In yrs. last birthday) Months Day	s Hours Min.	8. Date of Birth (Month, Day, Yeil May 15, 1		place (State or Foreign ntry) Land
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				0d. Inside City Limits
	f aho	o	MD Calvert County Prince Frederi	ck			1 ☐ Yes 21☑ No
	28a-	Director	10e. Street and Number 10f. Zip Code		100	Citizen of What Cour	
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	r death with the Marylar ems 23a or 28a-f ahow ermust be notified at	Funerai		Hispanic Origin? (Spotban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
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yland	should be nd Menta i marked umatic ev	ToB	Sellman Stanley Taylor		radford		
, Mary	and 2 st alth and 27 is n er treun		19a. Informant's Name/Relationship (Type, Print) Kenneth J. Weeks (Son) 19b. Mailing Address (Street Son) 920 Grovewoo				
more,	ges 1 a t of He if Item or othe		20a. Method of Disposition 1 Structure State 20b. Place of Disposition (Name of cemetery, crematory or other p.		^{20c.}	Location - City or To	own, State
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08/pn	physicien the buria	edicai	d				
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5	nding ath. r: Afte	atio		ork? ∃Yes 2⊟No			
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	the H hin 24 the F mplets	Medical	one) and manner stated.				
	or Jail		29b. Signature and little of certifier	se number	29d. [Date signed (Month,	Day, Year)
			Jame De pri- m) De	12005	l	12012	00 [
	5		30. Name and address of person who completed ause of death (Item 23a) (Type, Print) Part	DS. Jani	3 MADE	rich K	11) 20678
į	Stat		31. Date filed (Month, Day, Year) 32. Registrary Signature	1,1,100	- 1. Ca	richt I	11) 246 18
	Registra	T.	JUL O I CHUID AND AND AND AND AND AND AND AND AND AN	B)			

			State of Maryland / State of Maryland / Registrar	Department of Hea			ene . No.	1) (= ; ()
(S)	Physici	an	1. Decedent's Name (First, Middle, Last) WILLIE CLARENCE WATSON	-		2 Date of Death	7 ^{pay} 200 ^Y 7 ^{ar}	3. Time of Death
and Salar	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loc	cation of Death		4c. County of Death	9:25PM M
	Funeral		PRINCE GEORGE'S HOSPITAL CE 5. Social Security Number 6. Sex 7. Age (In yrs. last b	oirthday) if Under 1 Year If	HEVERL Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign
b	Director		241 38 8943	Yrs. Months Days F	Hours Will.	OCT 20	1931 N	intry)
	aryland show d at	_	10a. State 10b. County 10c. City, Tot	wn or Location				10d. Inside City Limits 1 Yes 2 No
	the Marchine	Director	MD P.G. 10e. Street and Number	GLENARDEN 10f. Zip Code		10g	. Citizen of What Cou	
	ath with		7809 GLENARDEN PARKWAY		706		USA 14. Race - Amer	ican Indian
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dleal Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1947 1 □ Yes 2 □ No 16 ff Yes, Give 7 ear or Dates: 1949	13. Was Decedent of Hispa if Yes, specify Cuban, I 1 ☐ Yes 2 ☑ No S	anic Origin? (Spe Mexican, Puerto <i>Specify:</i>	ecity Yes or No- Rican, etc.)	Black, White	, etc.
12-0(d within 72 hou giene. r than "natura the Medical E	Completed	(Specify only highest grade completed)	a. Decedent's Usual Occupatio (Give kind of work done during life. DO NOT use retired)	on ing most of worki	ing 16	6b. Kind of Business/I	
212	filed within Hygiene. Ither than "	Comp	Elementary/Secondary (0-12) College (1-4or 5+)	TECHNICIA	N		FED. GOV	т.
and	d d d	To Be	17. Father's Name (<i>First, Middle, Last</i>) NOT STATED	18		e (First, Middle, Ma A WATSC		
Maryland 21215-0036	2 shou and M is mar sumat	-		809 GLENARDE				
altimore,			20a. Method of Disposition 20b. Place ceme:	of Disposition (Name of tery, crematory or other place)		Date 20	ANDOVER,	Town, State
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8760,	icate be executed physician and s the burial-transit	dical E	d.	e (i).				
Box 68	leath certifical attending phy for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal dea				23d. Date of deli	very Day Year
P.0.	at the de by the a tached f	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5 Other (specify)				
	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting	in Part I.		acco use contribute to	3-2.	
Vital Records,		Completed				24a. Was an autopsy perform 1□ Yes 2	prior to o	topsy findings available completion of cause of
Vita	certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Impatient 2 ER/C	20 Outpatient 3 DOA Other:		h (Check only one) ace 6 □Other (Spec	nife)
Division or	nding Phys th. : After this e funeral di	ition: To		o. Time of lnjury at Work?		28d. Describe how		<i></i>
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	iral Route Number,
	To the Hospital of within 24 hours aft To the Funeral D completely filled in	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowled and manner stated.					
	To the vithin To the compl	Me	29b. Signature and title of certifier	29c. License n	umber	29	d. Date signed (Mont	h, Day, Year)
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4	8)		James + Akras	Prince Ge	orje	espital	Chever	4,40
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signatures 4.	ules				•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Litem 8 Prarylan 8878 04/08/08/the alth and Mental Hygiene AmendItem 25 per dr., g871,09/05/07shbeath 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Gywn Williams 08 04 2007 10:30 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kent Rock Hall 22520 Hudson Rd If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖫 F 64 02/24/1943 213-44-7982 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" --- any injury or other traumatic everal. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD Rock Hall Kent 1 TYes ZYT No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22520 Hudson_Rd 21661 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White by 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Web Developer Web Design 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Gwyn Branham Charles C.W. Atwater ဥ 19a. Informant's Name/Relationship (Type. Print)

Jennifer Riggs / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rock Hall, MD 21661 22520 Hudson Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 08/06/07 | Stevensville, MD Chesapeake Cremation 21. Signature of Funeral Service Licensee fellows, Helfenbein, & Newnam Funeral Home, P.A. pren Jella 130 Speer Rd. Chestertown, MD 21620 23a. Bart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician u romic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown cate has been signed by the page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 3N Probably 4 ☐ Unknown 1 Tes 2 🗌 No Completed | 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Okeck only one) Be Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home To 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

within 24 hours after death To the Funeral Director:

State Registrar

29b. Signature and title of cert

31. Date filed (Month, Day, Year)

30. Name and address of person who completed

Andrew Fergusch. MD

0

7 2007

D0051786

Chestertown

MD 21620

MD

cause of death (Item 23a) (Type, Print)

32. Registras Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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David	Lewis Andreiak	

	1- For State Certificate C	f Death Re	g. No.					
Physician/	Decedent's Name (First, Middle, Last)	Date of Death Month	Day Year 1840 hrs					
dedical Examiner	3	Month August 10, 4b. City, Town, or Location of Death	2007 TOTOTHS					
1	Facility Name (if not institution, give street and number) S54 Nicholson Road	Essex	Baltimore County					
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		h(MM/DD/YYYY) 9. Birthplace (State or Foreign					
Director	219-76-4455 1XM 2 F 47 Y	s. Months Days Hours Min: Nov 9,	Country					
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation	10d. Inside City Limits					
ow any		sex	1 Yes 2 X No					
Aaryland 28a-f show 1 at once. ector	MD Baltimore Es		g. Citizen of What Country?					
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tanger of Health and Mental Hygiene. To Be Completed by Funeral Director	354 Nicholson Road	21221	USA					
with ns 23.	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Navigation 2. Married Armed Forces?	as Decedent of Hispanic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.					
r death with or items 23 must be no Funeral	Never Married 2 Married 1 Yes 2 X No							
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5-0036 ed within 72 hour lygiene other than "natu the M. diral E. an Completed	12 0 mech	anic	refridgeration					
5-00 led with tygiene other the M	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, N	Maiden Surname)					
21215-0036 undibe filed within 7 Mental Hygiene. marked other than ic event, the Madra To Be Comple	Chester Andrejak	Helen Majka	7.0.4					
Should be fill and Mental Fills marked natic event, To Be		ng Address (Street and Number or Rural Route Num						
MD and 2 sho salth and 2 sin 27 is raumati	Helen Andrejak/mother 3841 20a. Method of Disposition 20b. Place of Disp	Bayville Road Baltimore position (Name of cemetery, Date	MD 21220 20c. Location - City or Town, State					
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Baltimore, permit. Pages I at Department of Hee Important: If ite	4 Donation 5 X Other Specify: in state	Name and Address of Facility	7 1.1 (1)					
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumat		Name and Address of Facility ate Anatomy Board 655 W. 1timore, MD 21201	Baltimore Street					
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not ente	the mode of dying, such as cardiac or respiratory arr	est, shock, or heart Approximate Interval Between Onset and					
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a, Contact Shotgun Wound toTorso		Death					
/Examiner	or condition resulting in death) Due to (or as a consequence of):	1.00						
n <u>e</u> l	Sequentially list conditions, b							
nine .	if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
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Box 687 e death certific the attending g ed for use as th	past 12 months? 4 Pregnant at time of death 5	Other (Specify)						
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COFC			ormed? death?					
Division of Vital Records, Into Attending Physician: The law requires rs after death. "In Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed		26.Place of Death (Check only one)	2 No 1 Yes 2 No					
ital iiciam: s certi irector		Othor:	Residence 6 🗸 Other: Scene					
of Vi	1 V Yes 2 No 22 No 23 Manner of Death 28a Date of Injury 28b. Time	of Injury 28c. Injury at Work? 28d. Describe	how injury occurred					
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risic r Atte er dez irecto n by tl	2 Accident Investigation Aug 10, 2007 1837 IIIS 3 Suicide 6 Could not be	reet, factory, office building, etc. 28f. Location or Town,	(Street and Number or Rural Route Number, City State)					
Division Division Hospital or Attend 24 hours after death. Funeral Director: stely filled in by the filled in the the death.	determined (Specify) Single Family	354 Nicholso	n Road, Essex, MD					
Hosp 24 ho Finne etely f	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death oc	curred at the time, date and place, and due to the cau	ise(s) and manner as stated.					
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician	(Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or investion and manner stated.		29d. Date signed (Month, Day, Year)					
A [] Š	29b. Signature and title of certifier	29c. License number O.C.M.E.	August 11, 2007					
(6)	Larde Hellan	O.O.IVI.E.						
(2)	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Pen	n Street, Baltimore, MD 21201						
9	20 De intende Cignolium							
State Registra								
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State of Maryland / Department of Health and Mental Hygiene

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	Physici /Medic		Kath leer		C	cates	· >		2. Date of Dea Month		07	S49pm
	Examin		4a. Fecility Name (If not institution, give	street end number)			4b. City,	, Town, or Lo	ocation of Death	4c. County of	of Death	
			HOILY MIL	ryano	DL.		10	WS2	on	100	M	nae
	Funeral Director		5. Social Security Number 6. Social Security Number 1 Usual Residence of Decedent	9X 7. Age (In yrs. last bir	Yrs.		der 24 Hrs. rs Min.	8. Date of Birth (Month, Day	Year)	9. Birthpl Scount	ace (State or Foreign
	land ow		10a. State 10b. County	1	0c. City, Tow	n or Location					10	d. Inside City Limits
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	or 28	je	10e. Street and Number		_	10f. Z	ip Code		1	0g. Citizen of W	hat Count	ry?
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	er dez	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was Dec	edent of Hispenic ecify Cuban, Mexi	Origin? (Sp ican, Puerto	ecify Yes or No- Rican, etc.)		- America c, White, e	
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Maryland 21215-0020	tal H d oth even	Be	17. Father's Name (First, Middle, Last)	11. 10				1	e (First, Middle,	Maiden Surnami	9)	
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ē,	s 1 and 2 f Health tem 27 I		20a. Method of Disposition		20b. Place of	f Disposition (N	am <i>e</i> 🐧 🔎		Date	20c. Location -	City or To	wn, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hybjene. Important: If them 27 la marked other than "natural; or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinat mant be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specify		Cerriete	iy, crematory or	Outer place)					
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ō	Phys rthis ral di	. To	1 ☐ Yes 2 No 27. Menner of Death	28a. Date of Injury	28b. 1	ıtpatient 3⊡ I Time of	28c. Injury et Work?	Nursing Ho	ome 5 🗆 Resid	ence 6 ∐Othe ow injury occurr		/)
0	th. : After s fune	tion	1 Naturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	(eer) 1	njury M	Work? 1 ⊟ Yes 2	2 □ No				
<u>S</u>	Atter or dea ector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury		ırm, street, facto	ry, office		28f. Location (S City or Tow	treet and Number State)	er or Rure	l Route Number,
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	ithin 2 or the	Med	one) 29b. Signature and title of certifier	and manner state	d.	. 2	9c. Licerise numb	er	. 2	29d. Date signed	(Month, i	Day, Year)
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			30. Name and address of person who	completed cause of dea	th (Item 23a)	(Type, Print)	0 0 1			A :	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	, (
			Ted HoukeME	7402	York	K9#	301,	1000	800 M	10 CI	20	7
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amend item 26 per verb 870 8 20 07 vt
State of Maryland / Department of Health and Mental Hygiene
Amend Items 5,23a per ship all of Deag 872,10/04/07dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 08 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Nicomi Hos Dice 6. Sex If Under 24 Hrs. at the Lak 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2▼F Min. Yrs. Director 87 May 11, 1920 Delaware Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f shov Examiner must be notified at MD Worcester Berlin 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10423 Racetrack Road 21811 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Specify. þ Specify: white 3 X Widowed 4 ☐ Divorced "natural" Completed any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 11 0 nurses aide healthcare Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi. Be WIlliam H. Niblet Lula M. Fletcher Pages 1 and 2 should ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 ls Michele Chesnik/step daughter 8128 Green Lewis Road Willards, MD 21874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages: Department of H Important: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from-State 4 ☑ Donation 5 ☐ Other (Specify) Funeral S . Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Signa Baltimore, MĎ 21201 nt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Intracranial Hemorrhage Immediate Cause (Final disease or condition resulting in death) Physician 2 hermer /Medical Due to (or as a consequence of) **Examiner** veloro vostula Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Box 687 IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Day Year signed by the a 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has by autop-performe 2 page After this certificate To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Dother (Specify) hospice 2 No 1 🗌 Yes P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 27, Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 Pending death. investigation 1 □ Yes 2 □ No 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed ause of death (Item 23a) (Type, Print) . Count) covid E past-1 31. Date filed (Month, Day, 32. Registrar's Signature Registrar

ORIGINAL

DHMH 17 Rev 1/2001

		•	State of Maryland / Dep	artment of Health and ertificate of Death		e 117	256
	Physici		1. Decedent's Name (First, Middle, Last) Dorothy Frances Baikauskas		2. Date of Death 08-13-200	ay Year	3. Time of Death
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	h 4	c. County of Dea	
- x1	All C	à,	2314 Queensbury Drive	Fallston		Harford	
*	Funeral Director		5. Social Security Number 219-38-8105 6. Sex 1 M 2 N F 7. Age (In yrs. last birthday 90 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		r) Co	thplace (State or Foreign puntry) ryland
	nyland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L Marron 1 and Thorse and T				10d. Inside City Limits
	Ba-f	Director	Maryland Harford FAllston				1 Tyes 2X No
	with t	Dir	10e. Street and Number 2314 Queensbury Drive	10f. Zip Code 21047		Citizen of What Co	ountry ?
	death	Funerai		Was Decedent of Hispanic Origin? (S ff Yes, specify Cuban, Mexican, Puer		14. Race - Ame	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23s or 28s-f show other traumatic event, its Medical Examination in a colline of a medical examination.	þ	1 ☐ Never Married 2 ☐ Marned 1 ☐ Yes 2 1 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	to Alcan, etc.)	Specify: White	ite
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lan)	2 should and Men is marks raumatic			ing Address (Street and Number or R			Zip Code)
	of Health Item 27 other tra			Queensbury Dr Fa		21047 Location - City or	Town, State
nor	Pages nent of I int: If Its iry or o		I (A Burial 2 Cremation 3 Hemoval from State				Maryland
Baltimore,	permit. Pages Department of Important: If It eny injury or o		21. Signature of Funeral Service Licensee	22. Name and Address of FacilitySch	nimunek Fune	ral Home	of Bel Air
44	4		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	Inc. 610 W. MacPhanter the mode of dying, such as cardia		AII, MD	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				y 2 225
	Examiner		Due to (or as a consequence of):				
	-,0*	Jer	Sequentially list conditions, if any learning transport in the cause. Enter Underlying Cause (Disease or injury			111	7202)
	acuted ind transit	Examiner	that initiated events C.				
760,	ficate be executed physicien and is the burial-transit	cai Ex	resulting in death) Last Due to (or as a consequence of):				
687	ficate phys		d				
Division of Vital Records, P.O. Box	Attending Physician: The law requires that the death certifica or death. • clostl. • ctor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the funeral director.	Completed by Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year
ري ح	s that pred b e deta	y Pi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute t	o the cause of death?
Srd.	equire en sig ould b	ted t	Chronic Quemia		1 🗆 Yes	2 1 No 3 □ P	robably 4 Unknown
Reco	tending Physician: The law r leath. tor: After this certificate has be the funeral director, page 2 sh	omple	Phenatoid Ardering		24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of
Ita	sian: artifica ctor, p	Bec	25. Was case referred to medical examiner?		ath (Check only one)		
<u>5</u>	shysic this co	P	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		lome 5 → Residence		ecify)
ouo	ding h. After funer	tion:	27. Manner of Death 1	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	jury occurred	
Divisi	l or Attendate after death Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Street City or Town, St.	and Number or Rate)	lural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal (Check only one) 1 Medical Examinar: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place	e, and due to the cause urred at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Mon	th, Day, Year)
}			Wand xlong mo	D3129F		8/15/02	
6	7		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) 7 inson md	21204		
<i>V</i>	Sta		31. Date filed (Month, Day, Year) AUG 1 8 2007 South The South T	·	-1204		
DHI	Registi MH 17 Rev 1/2		AUG I 8 2001 Brown B. B				

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 08^{Month} 1.7 Pay **Physician** 2007 8:05 Рм Charles Nicholas Cope Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Towson 7. Age (In yrs. last birthday) 55 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 15, 1952 Birthplace (State or Foreign
 Country) 5. Social Security Number **Funeral** Days Hours 1**X** M 2□ F Yrs. Maryland 213-60-5334 Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. ?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 No Baltimore Funeral Director Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 USA 16 1/2 Linden Terrace 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Defense Computer Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill thent of Health and Mental H tant: If item 27 is marked out Be Helen Marie Slade Charles Nicholas Cope Sr. ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 1/2 Linden Terrace, Towson, MD Susan G. Cope/Wife : If Item 27 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Hilltop Service Corp. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 08/20/2007 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Ruck Towson Funeral Home, Inc. <u> 1050 York Rd., Towson, MD 21204</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CISCHOSIS rears /Medical Due to (or as a consequence of): **Examiner** Heraths 10005 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and is the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has le 2 , page certificate Hospital or Attending Physician; 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSpi (C 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this c Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after wow...

To the Funeral Director: After the funeral part of the f 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certific D0051926 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Baltman 6905N. G ordu ND 32 Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

07-06126

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Ју Сапірі	Jell		-For State Critical Property	ficate of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Reg. No	o.	
Ph	ysicia		Registrar 1. Decedent's Name (First, Middle,Last)		- 1	2. Date of Death	Year	3. Time of Death
اد منظمها احتظمها			Roy Campbell			August 9, 200	7	1527 hrs
			4a. Facility Name (if not institution, give street and number)		Location of Death	1	4c. County of Dea	ath
			2300 Whittier Avenue	Baltimore				
Fur	neral	-	5. Social Security Number 1171 6. Sex 7. Age (In yrs. las			1	I Fore	Birthplace (State or eign North
	ctor		1X M 2 F 64	Yrs. Months Day	ys Hours Min.	May 1, 1	943	Country Carolina
		- -	Usual Residence of Decedent					
	any	-	10a. State 10b. County 10c. City, T	own or Location				10d. Inside City Limits
	*			D 154				1 Yes 2 No
yland	28a-f show	휘	MD 10e. Street and Number	Baltimore 10f. Zip Code		10g. C	Citizen of What Co	ountry?
Man	r 28a	Director		· ·	21217	tarvet to	USA	
h the	23a or 28a-f sho notified at once		2300 Whittier Avenue		_	ocify Ves or No-		nerican Indian, Black,
hours after death with the Maryland	t be r	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S Armed Forces?	If Yes, specify Cuba	an, Mexican, Puerto I	Rican; etc.)	White, etc	
deat	or it	딃	1 Yes 2 X No	1 Yes 2 X N	to coocifu	0.000	Specify:	black
after	ral",	<u>a</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:	16a. Decedent's Usual Occup		ork done 16t	o. Kind of Busines	
hours	xan		To: Decodarke Education (Epitem) and	during most of working lif	e. DO NOT use retir			
5	ical	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	440011	o.d		none	
003 with:	Ned t	E	9 0 17. Father's Name (First, Middle, Last)	disabl		(First, Middle, Maid		
	d of				Ola Mae			
21215-0036 uld be filed within 7	Menial riggiene. marked other than "natural", c event, the Medical Examiner	o Be	Robert L. Campbell 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Str	eet and Number or F	Rural Route Number	, City or Town, S	tate, Zip Code)
D 2	is in	ř		3724 Fernda				21207
, MD 2121	item 27 tranma		Mary Love/sister 20a. Method of Disposition 20b. F	Place of Disposition (Name of o	cemetery,	Date 20	c. Location - City	
S I S	= =			rematory or other place)				
im C	ant:		4 Dopation X Other Specify: in state		-6 5 - 110-11			
Baltimore,	Department of Important: injury or otl		21. Signature of Funeral Service Licensee Ronald S. Made, Director	22. Name and Addre	tomy Board	655 W.	Baltimor	e Street
a 8.	ă . E. E.	1	din - 1/1/1/10	IKaltimore.	. MD 2120) [Approximate Interval
	ician		28a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.	Do not enter the mode of dyll	ig, such as cardiac o	respiratory arrest,	SHOOK, OF HOUSE	Between Onset and Death
	dical niner		Immediate Cause (Final disease a. Complications of		abuse			Death
\u_i			or condition resulting in death) Due to (or as a consequence of	f):				
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		Examine	cause. Enter Underlying Cause			155		
/		cam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	f):				,
executed	nd ransi		d					
	physician and he burial - transit	Medical	X UNPENDED #MENDES7, perME, g8	70. 8/23/07 TT				
68760, certificate be	hysic e bur	Med	IF FEMALE: 23c. If yes, outcome of preg				23d. Date of del	
87 rtificz	as th	an/	23b. Was decedent pregnant in the	2	3 Ectopic pregna	ancy	Month	Day Year
× e	ttend r use	iç.	4 Pregnant at time of de	eath 5 Other (Specify)				
Records, P.O. Box 687	certificate has been signed by the attending p ector, page 2 should be detached for use as th	Physician/	o on one	War is the condenting cour	no given in Port I	23e Did toba	cco use contribu	te to the cause of death?
a to	ed by etach	by P	Part II. Other significant conditions contributing to death but not r	esulting in the underlying caus	se given in rairi.			Probably 4 🗸 Unknown
G, P	sign I be d	g				24a. Was an	I The Bridge	re autopsy findings available
P P	been	Completed				autopsy	prio	or to completion of cause of
e law	e has	E D				perform 1 ✓ Yes 2	ed? dea	Yes 2 No
	ificat ır, pa	ပိ		26.Pl	ace of Death (Check	only one)		
ital	s cert irecto	Be	examiner? Hospital: 1 inpatient 2	ER/Outpatient 3 DOA	Other Nursi	ng Home 5 R	esidence 6	Other: Scene
Division of Vital Records, P.O.	ours after death. cral Director: After this certifi filled in by the funeral director,	2	1 V Yes 2 No	28b. Time of Injury 28c.	Injury at Work?	28d. Describe ho	w injury occurred	
n o	h. : Aft	Certification:	1 X Natural 5 Pending (Month, Day, Year)	1	Yes 2 No			,
SiO Atten	after death. Director:	cati	2 Accident Investigation 28e Place of Injury - At h	nome, farm, street, factory, office	ce building, etc.	28f. Location (Str	eet and Number	or Rural Route Number, City
<u>;</u> <u>₹</u> ;	after Dire	ij	3 Suicide 6 Could not be determined (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3	or Town, Sta		
Spirit C	24 hours after Funeral Dire		4 Homicide 29a. Certifier A Certifying Physician: To the best of my knowled	t - tth accurred at the time	data and place an	d due to the causel	s) and manner a	s stated.
Division of Vital	within 24 h To the Fur completely			age, death occurred at the time and/or investigation, in my opi	nion, death occurred	at the time, date ar	nd place, and due	e to the cause(s)
ro th	within 7	Medical	and manner stated.		ense number			(Month, Day, Year)
		2	29b. Signature and title of certifier		.C.M.E.		August 10, 2	
			Mhu Grasself, Mis					-
			30. Name and address of person who completed cause of death (Itel		L Dalling and 145	24204		
			Melissa Brassell, MD Assistant Medical Exam		t, Baitimore, ML	7 2 1 2 0 1		
		State	B 1 1 10 7 7 1 11 / 80 A -	ture				
	Regi	stra	AUG 1 8 2007 Beauce	N' APPRACE				

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

		1 - For Amend Item 2	State of Ner	Maryland / (erb., g870	epa Cen	7207200 tificate	Health a	and Me		ene	97	25614
		Decedent's Name (First, Middle, Las	t)						2. Date of Death	1		3. Time of Death
Physic /Medi		Richard P. Douce	tte						Month August	Day 2007	Year	8:00 AM M
Exami		4a. Facility Name (If not institution, give	street and number	er)		4b. City, Tow	m, or Location	of Death		4c. County	of Death)
		14132 Green Cast		[‡] D			stown			Wash	ingt	on
Funeral Director		003-32-4036	x 7 7 M 2□F	Age (In yrs. last bir 73	thday) Yrs.	If Under 1 Ye Months Da	ear If Under ays Hours	Min.	B. Date of Birth (Month, Day, lar 14,	^{Year)} 1934	9. Birth Cou Mai	place (State or Foreign intry) ne
and	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation						10d. Inside City Limits
Maryl f sho	jo	MD Washing	rton		Цас	roretor	m					1 ☐ Yes 2 ☐ No
7.28a	Director	10e. Street and Number	31011		пав	gerstow 10f. Zip Coo			10	g. Citizen of V	Vhat Cou	
h with		14132 Green Cas	tle Pike	#D		217	40			US	Α	
deat	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S.	13. W	as Decedent	of Hispanic Ori Cuban, Mexicar	igin? (Spec	ify Yes or No-		e - Ameri k, White	ican Indian,
permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	ρ	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	12 Yes 2[If Yes, Give Year or Date:	□No	1	☐ Yes 2🏋			,,	Specify		nite
72 ho	Completed	15. Decedent's Ed (Specify only highest gra-	ucation de completed)	16a.	Decede	ent's Usual Oc	ccupation one during mos	at of working	unk	6b. Kind of Bu	siness/Ir	ndustry
Athin 100 Per	Jd II	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. D	O NOT use re	etired)					
lied v lygie rt, fb		11 17. Father's Name (First, Middle, Last)	0				19 Mothe	or's Name /	First, Middle, M		aint	ing
d be t	Be C	Anselme Doucette	2						oucette		9)	
should be mark mark	오	19a. Informant's Name/Relationship (7		19b	. Mailing	Address (St			Route Number,		State Zi	n Code)
Mich ar lith ar 27 is r trau	1 3	Richard Doucette			_				ce #D Ha	•		
S 1 ar T Hee other		20a. Method of Disposition		20b. Place of	Dispos		f !	Da	-	Oc. Location -		
circii. Peges partment of portant: if it y injury or o	1 23	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specify		te	ry, cremi	atory or other	place)					
Dermit. Departiments imports any inj		21. Signature of meral rice Licen	Wade, Di	rector			atomy B		655 W.	Baltimo	re S	Street
		23a. Part1. Enter the disease, or corns shock, or heart failure. List only	lications that caus	sed the death. Do i					respiratory arre	st,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	AH	1 1 /	OZ AL	Jan V	Ascula	Disc	مده			Onset and Death
/Medical		resulting in death)	W	as a consequence		-	7-000					
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ed sit	Je e	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequence	Ot):							
cate be executed obysicien and the burial-transit	Examin	that initiated events resulting in death) Last	c Due to (or	as a consequence	of):							
ate be ex hysicien the burial	al		d									
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DIVISION OF VITAL INCOMES, F.C. DOX 00100, othe Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. othe Funeral Director: Atler this certificate has been signed by the attending physicien and ormpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death		Ectopic pregna Other (specify				23d. Date Mor		very Day Year
that that ned by deta		Part II. Other significant conditions co	ntributing to death	but not resulting in	n the und	derlying cause	given in Part I		23e. Did tob	acco use contr	ibute to	the cause of death?
quires quires no sign	ed by								1 ☐ Ye	s 2□No	3 □ Pro	bably 4 Unknown
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ificet	ပိ	25. Was case referred to medical					DE Blood	a of Dooth /	1 □ Yes 2 Check only one	100	□Yes	2 No
ysicia ysicia s cert	0 0	examiner?	Hospital:	atient 151VOu	itpatient	3□ DOA	Other		e 5√2 Resider		er (Speci	ify)
ding Ph After thi funeral	lon: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Ir	njury 28b. 1	Time of njury	28c. I	Injury at Work? 1 □ Yes 2 □	28	ld. Describe how			-17
Attended of deatlest of the	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of	Injury - At home, fa	ırm, stre			-			er or Rur	al Route Number,
urs ette		4 Hornicide		etc. (Specify)					City or Town,			J. Company
To the Hospital or Attending Physician: The law Within 24 hours elfer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 ☐ Certifying Phyone) 1 ☐ Certifying Phyone	rsicien: To the be iner: On the basis and manner	st of my knowledge of examination an stated.	e, death d/or inve	occurred at the estigation, in r	ne time, date an ny opinion, dea	nd place, an oth occurred	d due to the ca d at the time, da	use(s) and ma te and place, a	nner as : and due !	stated. to the cause(s)
Vith To t	Σ	29b. Signature and title of certifier					cense number		29	d. Date signed	(Month	, Day, Year)
			nE				00569	45		Augus	7 11	, 2007
		30. Name and address of person who o					17	1		0		
C+	ate	31. Date filed (Month, Day, Year)	32. Regi	trar's Signature	m	street	Hag111	5TOWN	, MO	21140		
Regist		AUG 2 0 2	007	strar's Signature	A	ander						

Examiner Division or Vital Records, P.O. Box 68760,

requires that the death certificate be executed physician has certificate or Attending Physician: this

sician and burial-trans the signed by the a page 2 nours after death.

neral Director: After this
filled in by the funeral d within 24 hours a

Physician

/Medical

Examiner

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Director

r 28a-f show notified at

an "natural", or items 23a or Medical Examiner must be r

than the M

and Mental Hygiene.

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27 item 2

= 5 Department of Important: If any Injury or once.

Physician

/Medical

Pages 1 and 2 should be f nent of Health and Mental

Director

Funeral

2

Completed

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Examiner

Physician/Medical

Completed by

Medical Certification: To Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

GANRIC	ULCERATION		1 ☐ Yes 2 ☐	No 3 Probably 4 Donknown
			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner?		26. Place of Death (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing Home	e 5 ☐ Residence 6	□Other (Specify)
27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, fa	Work? 1☐Yes 2☐No	d. Describe how injury f. Location (Street and	occurred Number or Rural Route Number.
4 ☐ Homicide determined	building, etc. (Specify)		City or Town, State)	
29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	nysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, an lation, in my opinion, death occurred	d due to the cause(s) d at the time, date and	and manner as stated. place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. Date	e signed (Month, Day, Year)
h h n c	M D	D0059107	08	-14-2mz

08-14-2007

MD 21136

REISTERSTOWN

State Registrar mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physician /Medical Examiner 2007 executed Box 68760, The law requires that the death certificate be

Ö

Division or Vital Records.

Hospital or Attending Physician;

ELLIGSON

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u>

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Health a tem 27 ls

injury or other

Department of Important: If It any injury or o

Baltimore, Maryland 21215-0036

/Medical

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burial-tran attending physician and sate has been signed by the a page 2 should be detached to certificate this neral Director: /

ed by	- Tartii, Otter signincant conditions of	on and the death but not res	alting in the underlying	J cause given in Fait i.		No 3 Probably 4 □Unknown
Completed					24a. Was an autopsy performed? 1∐ Yes 2 🔀 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 № No
Be	25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)	
P	1 ☐ Yes 252 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	G □Other (Specify)
Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
Certificatio	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact fy)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
Medical C	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Example 1	yslcian: To the best of my kno piner: On the basis of examina and manner stated.	owledge, death occurration and/or investigation	ed at the time, date and pla ion, in my opinion, death oc	ce, and due to the cause(s) curred at the time, date and	and manner as stated. place, and due to the cause(s)
Me	29b. Signature and title of certifier		1 2	29c. License number	29d Dat	e signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (

WRIGHT

Year)

AUG 2 0

ERNESTINE

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

To the Funeral

DULANEY VALLEY ROAD

TIMONIUM, MD 21093

em 23a) (Type, Print)

2300

32 Registrar's Signature

M.D

			1 - For State of Maryland / Department of Registrar Ceres	artment of Health and M tificate of Death	lental Hygie	_ 1. U U I	26617
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medi		John Elwell		July 2:	2 ^{Day} 2007 2007	3:15 PM M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			7999 Noll Park Court	glen Burnie		Anne Arı	
	Funeral Director		5. Social Security Number unk 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Apr 25,	9. Birth Con	nplace (State or Foreign untry) unk.
	and and		Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation			10d. tnside City Limits
	Mary I-feh	ţō	MD Anne Arundel G1	en Burnie			1 ☐ Yes 2√∑ No
	th the	irec	10e. Street and Number	10f. Zip Code	10g	Citizen of What Cou	untry?
	ath wi	rai	7999 Noll Park Court	21061		USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "naturel", or Iteme 23s or 28s-f ehow other traumatic event, the Medical Examinar must be indiffed at	by Funeral Director	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No	Vas Decedent of Hispanic Origin? (Spei Yes, specify Cuban, Mexican, Puerto ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
ညှ	72 hou	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give.	ent's Usual Occupation	16	o. Kind of Business/l	ndustry
7	dithin	mple	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of worki OO NOT use retired)			
2	iled w Hygiei Ther ti	S	8 0	die maker unk 18. Mother's Name		anufacturi	ing unk
au	d be f	To Be	17.1 ditel 3 failing (17.3), innote, Easty	unk 18. Mother's Name	(First, Middle, Mai	den Sumame)	unk
Maryland 21215-0036	shoul ind Mu mari	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	g Address (Street and Number or Rura	l Route Number, C	ity or Town, State, Zi	ip Code)
	and 2 valth a valth a valth a		T7 1 7 77 44 /	Smith Avenue Evans			
altimore,	permit. Pages 1: Depertment of He Important: If Iten any Injury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in State	sition (Name of Diatory or other place)	200 ate	c. Location - City or T	
Balt	permit. Depert Import any Inj once.		21. Signature of Funeral Service Licensee Ronald S. Wade, Director S.	Name and Address of Facility tate Anatomy Board altimore, MD 2120	655 W. 1	Baltimore	Street
	Physician		shock or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death) a	rotic Heart	V130	ASE	
	be isi	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
Ö,	cate be executed physicien and the burial-transit	Examine	that initiated events resulting in death) Last c. Due to (or as a consequence of):				
9/89		edical	d				
C. Box	that the death certificated by the attending properties as	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	rery Day Year
л Г	8 P 8	þ	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		co use contribute to	
Hecords	w requires t been signe should be	etec			1 Tes		
		Completed			24a. Was an autopsy performed 1 Yes 2 🖫	prior to co	opsy findings available ompletion of cause of
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 □ No Hospital: 1 □ Inpatient 2 □ ER/Outpatient	26. Place of Death 3 DOA Other: 4 Nursing Hor			
0	ding Phys h. After this funeral di	ı.	27. Manner of Death 28a. Date of Injury 28b. Time of	4 Nursing Hon	8d. Describe how i	6 □Other (Speci njury occurred	ry)
2018	Attending r death. ector: After by the fune	atio	2 Accident investigation	M 1 Yes 2 No			
DIVISION	tal or Att s after de al Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office 2	8f. Location (Stree City or Town, S	t and Number or Run tate)	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	nd due to the caused at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
)	To T	Σ	29b. Signature and title of certifier Signature and title of certifier Deputy on 5	29c. License number 06054	29d.	Date signed (Month,	Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, P	95 Americ	A 21	035	
	Sta Registra		31. Date filed (Month, Day, Year) AUG 1 8 2007 32. Registrar's Signature	all)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 200 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner cmonDate of Birth (Month, Day, Year) July 31, 1911 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 X F 96 Days Hours Months 196-01-0436 Pennsylvania Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Maryland Howard Columbia 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? U.S.A. 10f. Zip Code 21044 6336 Cedar Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify **9**uban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 No if Yes, Give 11. Marital Status 14. Race - American Indian, 1 ☐ Yes 21 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Agnes Murphy Pat Kearney ဥ 19a. Informant's Name/Relationship (Type. Print) ing Address (Street and Number or Rural Route Number, City or Town, Stat 5072 Bucket Post Court Columbia, Maryland 21045 Daughter Ms. Geraldine Flynn 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 08/22/07 Avoca, PA St. Mary's Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Kniffen, O'Malley Funeral Home
728 Main Street Avoca, PA 18641 M01293 23a. Part1. Enter the disease or complications that caused the dea shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No the 9☐Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2□ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Hospital: 1 Yes 2 No Other: 1 🔲 Inpatient P 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 2 ER/Outpatient 3 DOA this Director: After th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

31. Date filed (Month, Day, Year)

Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav **Physician** 20:53 Donald August 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The JOHNS HOPKINS HOSPITAL BALLIMORE CITY If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F 215-14-0074 87 Director 02-03-1920 Maryland Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County r 28a-f show notified at 10d Inside City Limits Maryland Harford Forest Hill Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 12 mounts.

Pages 1 and 2 should be filed within 12 mounts.

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The file of fleath and fleath fleath fleath fleath.

The event, the Medical Examiner must be reserved. 206 Kimary Ct Unit 2B 21050 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Aq. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Logistic Engineer Aero space 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emil Funk Georgia Owings 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Della Funk (Wife) 206 Kimary Ct Unit 2B Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bavview Crematory 4 □ Donation 5 □ Other (Specify) 08-16-2007 Baltimore, MD 21224 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir 0 Inc. 610 W. MacPhail Rd Bel Air MD 21014 23a. art1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List they one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cardiac arrhythmia (verticular Ebsillation 6 duys /Medical Due to (or as a consequence Examiner myocardial infarct if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examiner Due to (or as a consequence of): artery disease yeurs and burial-trar attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 diubetes mellitus, hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed hyperlipidenia 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 212 No Hospital 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier

To the Hospital of within 24 hours at To the Funeral C

Attending

Hospital or

death.

Baltimore, Maryland 21215-0036

be executed

Box 68760,

Division or Vital Records, P.O.

State Registrar

DHMH 17 Rev 1/2001

Medical

29b. Signature and title of certifier

Stay Wang, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

, MEDICAL DOCTOR

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES- 000

29d. Date signed (Month, Day, Year)

August 14, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 16b per fb 9870 8-20-07 yt
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		viai yiai		rtificate of	Death	, ,	gierie Reg. No.2	0.7	21520
华	Physici	an	Decedent's Name (First, Mid-	dle, Last)					Date of Dea Month	nth Day	Year	3. Time of Death
	/Medi	cal	Marie Garbus 4a. Facility Name (If not instituti	ion give atreat and numb	n.el		4h City Tayya			18, 20		11:48a ^M
	Examir	ier	St. Martin's F	. 0	91)			or Location of Death	1	4c. County		
-	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs.	last birthday)		If Under 24 Hrs.	8. Date of Birth (Month, Day		imore 9. Birthp	lace (State or Foreign
L	Director		212-03-2259 Usual Residence of Decedent	1 □ M 2 💢 F	98	Yrs.	Months Days	Hours Min.	01/24/1	, Year) 1909	Mary	land
	aryland show d at	_	10a. State 10b. Count	ty	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	ne Ma 8a-f s	Director	Maryland Balti	more	Cat	consvil						1 □Yes 2 No
	with ti	Ö	10e. Street and Number				10f. Zip Code		1	I0g. Citizen of \	What Coun	try?
	leath	Funeral	601 Maiden Cho	pice Lane 12. Was Decede	nt Ever in U	S 13 1	21228	Hienanic Origin? (S.	pocify Voc or No	United	State e - America	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once.		1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	Armed Force 1 ☐ Yes 2 If Yes, Give	s? X No		f Yes, specify Cub 1 ☐ Yes 2 ☐ No	dispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)		ck, White,	
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121	vithin ne. han " e Mec	mple.	Elementary/Secondary (0-12)		or 5+)	life. l	DO NOT use retire	Tailor	King			
2	Hygie Hygie ther th	S	17. Father's Name (First, Middle	e I acti		Taylo	r		ne (First, Middle, i	Clothin		
Maryland	ental l ked or c eve	To Be	Petras Vysniau						aplinska		ie)	
ary	shoul ind M s mari	F	19a. Informant's Name/Relation			19b. Mailin	g Address (Street	and Number or Ru			State, Zip	Code)
	and 2 salth a n 27 is er tra		Cindi Jorgense	en - Niece			8th Squa		ero Beach		-	
ore	of He of He fitem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		20b. F	Place of Dispo	sition (Name of natory or other place anisiaus			20c. Location -		
ij	Pag ment tant: I		4 Donation 5 Other (le Sa	Cemet		08/2	2/2007	Baltimo	re, M	Maryland
Baltimore,	permit Depart Import any in		21. Signature of Funeral Service	e Licensee				ss of Facility Weber Fun	eral Hom	es P.A.		T
ķ			3a. Part1 Enter the disease, on shock, or heart failure. Lis	or complications that caus	sed the deat	h. Do not ent	311 Folmon er the mode of dyin	ndson Ave ng, such as cardiac	or respiratory arm	imore, est,	Mary.	Land 21229 Approximate
	Physician		Immediate Cause (Final disease or condition	R	MA	1 1	ailu	1				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a conseq	uence on	0	1 1	. 1			
H	Examiner	-	Sequentially list conditions,	b	nge	STIUT	hear	t fa	ilure			
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	4 H.	o a conseq	uence of):	1150	•				
<u>,</u>	execu n and ial-tra	Exar	that initiated events resulting in death) Last	cDue to 6	as a conseq	uence of):	WW I					
68760,	tificate be executed g physician and as the burial-transit	ledical Examiner		d								
	ng ph	Medi	IE EEMALE:									
30	ath ce ttendii or use	jan/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐Live birth	2 Feta	Ideath 3□	Ectopic pregnancy	/			e of delive	•
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	1 ☐ Yes 2 🌠 No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5□	Other (specify)			Мо	ntri	Day Year
o, O	signed b	y P	Part II. Other significant condit	tions contributing to death	but not resu	ulting in the un	derlying cause give	en in Part I.	23e. Did tob	pacco use contr	ribute to the	e cause of death?
Records,	w require been sig	Completed by	Dementia	,		-			1 □ Y∈	es 2 TNo	3 ☐ Proba	ably 4 □Unknown
ec	law r las be	ple							24a. Was ar		Vere autop	osy findings available appletion of cause of
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ō	Phys r this ral dii	은	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpa		ER/Outpatient 28b. Time of	28c. Injur	4 A Nursing Ho	ome 5 Reside)
on	Attending Physician: r death. ector. After this certifica by the funeral director, I	l i	1 XNatural 5 ☐ Pendi 2 ☐ Accident invest	/8 # AL F	Day Year)	Injury	Worl	k? Yes 2 □ No	200. Describe No	w injury occurr	eu	
Division or Vital	· Atter	Certification:	3 Suicide 6 Could	mined 28e. Place of I	ا njury - At ho etc. <i>(Specif</i> i	me, farm, stre	et, factory, office		28f. Location (St		er or Rural	Route Number,
Ō	ital or rs afte ral Dir led in	Cert							City or Town			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 X Certifyi (Check only one) 2 Medica	ing Physician: To the bes Il Examiner: On the basis and manners	of examina	wledge, death tion and/or inv	occurred at the ting restigation, in my o	ne, date and place pinion, death occu	and due to the carred at the time, d	ause(s) and ma ate and place,	nner as sta and due to	ated. the cause(s)
	To the Hos within 24 h To the Fun completely	ĕ ⊠	29b. Signature and title of certific				29c. License	e number	25	9d. Date signed	I (Month, E	Day, Year)
)	4		1 Park	aran			021	bumber				
	0 '		30. Name and address of person SAMBANDAM	n who completed cause of	death (Item	23a) (Type, F	Print) Kens A	WT. BA	LTIMOR	E	102	1229
	Sta Registra		31. Date filed (Month, Day, Year	65	trar's Signa		- N					

07-06365

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	State of Maryland / Department of Health ar For State Certificate of Death	Reg. No.
hysician/	egistrar I. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year 1257 hrs
Examiner	Thomas N. Gwin, Sr.	August 17, 2007
	Ha. Facility Walte (if flot institution, give salest and	D. H. County
	1022 Chairindii Noad	Timorium
T ullelal	Months Da	Foreign
Director	214-14-2320 1XM 2F 86 Yrs.	. 11/ 10/ 1320 7/10
8.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	MD Baltimore Lutherville Ti	momi⊔m 1 _Yes 2 ∑ No
yland I-f sh once	10e, Street and Number 10f. Zip Code	
ith the Maryland 23a or 28a-f show any notified at once. al Director		093 U.S.A.
23a anotif	113 Was Decedent Ever in U.S. 13. Was Decedent of	Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
or items 23 must be no Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cub	white, etc.
ter de ", or er mu	3 XWidowed 4 Divorced If Yes, Give Year 44-45 1 Yes 2 x 1	No specify: Specify:
urs aft turai" amine d by	16a Decedent's Usual Occur	pation (Give kind of work done ife. DO NOT use retired) 16b. Kind of Business/Industry
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5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan Completed	12	18.Mother's Name (First, Middle, Maiden Surname)
5-0 lled w Hygid	17. Father's Name (First, Middle, Last)	Nettie May Forney
121; d be fill lental I arked arked	Oriell B. Gwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (St	reet and Number or Rural Route Number, City or Town, State, Zip Code).
D 21 should and Me 7 is ma natic ev	Thomas N. Gwin, Jrson 2107 Folks	tope Rd. Timonium, MD 21093
, M and 2 ealth cem 2 traun	20a. Method of Disposition 20b. Place of Disposition (Name of	cemetery, Date 20c. Location - City or Town, State
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t. Pag	4 Donation 5 Other Specify-11 Community	ess of Facility Ruck Towson Funeral Home, Inc.
Baltimore, MID 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Important: If item 27 is marked other than "maturai", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	/// 1050 Yorl	k Rd., Towson, MD 21204
ysician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dy	ng, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Carbon Monoxide Intoxication	Death
Examiner	or condition resulting in death) Due to (or as a consequence of):	
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0, e be execut sician and burial - tra edical	UNPENDED	23d. Date of delivery
Box 68760, e death certificate be the attending physic of for use as the burthy significant Medical Medical Medical Medical Medical Box 100 Medical Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death	3 Ectopic pregnancy Month Day Year
b. Box 6876 the death certificat by the attending phy ched for use at the	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
Box death death d for u	1 Yes 2 No 9 Unknown 9 Unknown	use given in Part I. 23e. Did tobacco use contribute to the cause of death?
tal Records, P.O. Box 6876 cian: The law requires that the death certificate certificate bas been signed by the attending phycicior, page 2 should be detached for use as the Completed by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	1 Yes 2 No 3 Probably 4 Vunknown
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n: Ti	25. Was case referred to medical	Place of Death (Check only one)
F Vital Physician: r this certif	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should the contification: To Be Completed.	27 Manner of Dooth 28a Date of Injury 28b, Time of Injury 28c	Injury at Work? 28d. Describe how injury occurred Inhalation of exhaust fumes
ion tendir eath. or: A	Natural 5 Pending Investigation Pound: 1250 hrs 1250 hrs	Yes 2 ✔ No fice building, etc. 28f. Location (Street and Number or Rural Route Number, C
or At fler d Direct in by	2 ✓ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, of	or Town, State) 1622 Charmuth Road, Lutherville Timonium, MD
Division of spiral or Attending hours after death. neral Director: After filled in by the function	4 Homicide determined (Specify) Single Family	
		ne, gate and place, and que to the cause(s) and manifer as stated. pinion, death occurred at the time, date and place, and due to the cause(s)
To the How within 24 h To the Furcompletely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in the sale and manner stated.	icense number 29d. Date signed (Month, Day, Year)
		D.C.M.E. August 18, 2007
10+1	30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penp Street,	Baltimore, MD 21201
0	Such Titles in S.	<u> </u>
	31. Date filed (Month, Day, Year) 2 0 20 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend 20c, perFH, 23a, perVD, g870, 8/20/07 Time. Ensure All Copies Are I 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vear Physician LOUIS GREENWALD 11:50 A M **AUGUST** 16 2007 /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner LEVINDALE HEBREW HOME BALTIMORE N/A Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 95 1**X** M 2□ F 081-01-0733 POLAND 12/25/1911 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show notified at 1X Yes 2 No MD N/A BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number purmit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be nother. U.S.A. 21215 2434 W. BELVEDERE AVENUE Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 Specify. Specify: 2 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) WATCH BANDS **SELF EMPLOYED** 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN GREENWALD SEMA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3829 MENLO DRIVE - BALTIMORE, MD 21215 SEMA ELY / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) UNION FIELD Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIDGEWOOD, NJ NY 08/17/2007 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses Scott M. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAL FAILURE Physician a years /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by MISICASE 1 ☐ Yes 3 Probably 4 Unknown with Advanced PAKINSONS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No hype tension 24a. Was an autopsy 1□ Yes 2 110 Anemia To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 030377 August 16,07 120BERT M. COOPER MO VE VW ZIZIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIL Heights Are BALTIMONE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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			For State Registrar	State of M	aryland 7 Der Ce		ment of H ficate of I		d Me		jiene Reg. No.	0000	25	522
			1. Decedent's Name (First, Middle, L	ast)					2.	Date of Dea Month	ith Day	. Van	3. Time o	of Death
	Physici /Medic		James Leo Hiser						A	ugust			12:46	AM [™]
	Examir		4a. Facility Name (If not institution, g	ive street and number)		4	lb. City, Town, or	Location of De	eath		4c.	County of Dea	ath	
			Joseph Richey Ho				Baltim							
(kr	Funeral			Sex 7. Ag 1 1 M 2 □ F	ge (In yrs. last birthda Yrs.		If Under 1 Year Months Days	If Under 24 H Hours M	/lin.	Date of Birth (Month, Day	r, Year)	C	rthplace (State ountry)	or Foreign
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	/land low at		10a. State 10b. County		10c. City, Town or	Loca	tion						10d. Inside C	City Limits
	Mar a-f sh iffed	tor	MD		Baltimor	ce							1X Yes	s 2 □ No
	th the or 28a e not	Director	10e. Street and Number				10f. Zip Code			1	10g. Citi	zen of What C	ountry?	
	th wii	al [4805 Frederick A	venue			2122	29				USA		
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	3. Wa	s Decedent of Hi es, specify Cuba	ispanic Origin? an, Mexican, Pu	? (Specif	y Yes or No-		14. Race - Am Black, Whi		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show ent, <u>the Medical Examiner must be notifled at</u>	by	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 √ Yes 2 ☐ If Yes, Give Year or Dates:	No		Yes 2⊠ No	Specify:		, ,		Specify: wh:		
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anc	be fi	Be	17. Father's Name (First, Middle, La. Arthur Clinton H	*				18. Mother's I		rauss	maiden	Surname)		
Ž	2 should and Men Is marke aumatic	은	19a. Informant's Name/Relationship		19h Ma	ilina	Address (Street a				r City o	r Town State	Zin Cada)	
Maryland	and 2 s ealth ar n 27 ls ier trau		Joseph Richey Ho				utaw Sti						Zip Oode)	
	s 1 ar f Hea f Hea item 3		20a. Method of Disposition	эртсе	20b. Place of Dis	positi	on (Name of	Leet ba	Date			21201 ecation - City or	r Town, State	
E O	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 ☐ Cremation 3 4 🕅 Donation 5 ☐ Other (Spec		cemetery, cr	ema	ory or other plac	:6)						
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.		21. Signature of Euneral Service Lice Ronald S	ensee all	ector S	Sta	lame and Addres	omy Boa		555 W.	Bal	timore	Street	
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b	Examiner			. Duo to (or as	a conservation.								,	
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			30. Name and address of person wh	completed cause of d	leath (Item 23a) (Type	e, Pri	nt) Ave	Ba 1	tur	crc	M	17 2	122	4
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100	· · · · · · · · · · · · · · · · · · ·		ONIVERSITY OF MARTIE	7. Age (In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth	l 9 Ri	irthnlace (State or Foreign
	Funeral Director		218-42-0033 1√2 M 2□ F	64 Yrs.	Months Days	Hours Min.	Month, Day, June 11		irthplace (State or Foreign Country) arvland
			Usual Residence of Decedent				June 11	1943 Ma	
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	ns 23	Funeral Director	11 Marital Status 12. Was De	cedent Ever in U.S. 13.	212 Was Decedent of Hill If Yes, specify Cuba		cify Yes or No-	14. Race - Am	
30	within 72 hours after death with the Maryland ene. than "natural" or items 23a or 28a-f show he Medical Examiner must be notified at	by Fur	Armed F	2 X No iive	If Yes, specify Cuba 1 ☐ Yes 2 🗖 No	n, Mexican, Puerto I Specify:	Rican, etc.)	Black, Wh	
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פ	al Hyg other vent,	BeC	17. Father's Name (First, Middle, Last)		unk	18. Mother's Name	(First, Middle, N	Maiden Surname)	
/land	should be ind Mental marked o	ToE				Helen	Young		
Mary	2 sho and I is ma		19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ling Address (Street a	and Number or Flura	l Route Number	; City or Town, State,	Zip Code)
رة ج	1 and 1 Health em 27 ther tr		Vincent Manley/half bro	20b. Place of Disp	71 S.W. 42		Ocala,	FL 34476 20c. Location - City of	or Town State
Saltimor	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other to once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ※ Other (Specify) in S	n State cemetery, cre	ematory or other plac			zoor zoodkor, ony c	
Balt	permit. Depart Import any inj once.		21. Signature Pruneral Service Licensee Ronal S W	Director S	22. Name and Addres State Anat Baltimore,	omy Board		Baltimore	Street
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	Sta Registi		31. Date filed (Month, Day, Year) 32.	Registrar's Signature	mele				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) John Richard Hill 2007 1:55p 17 August 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | November 27, 1926 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Country) Ohio Months Days 1XM 2□F 80 223-30-1920 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21093 United States 12261 Roundwood Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1945–47 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white 3. Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) technician/repairman printing press service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cora E. Gardner John D. Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hunt Valley, MD 21030 18 David Luther Ct. Donna McPhail/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory Aug. 22,2007 Baltimore, MD 4 □ Donation 5 □ Other (Specify) ^{22. Name and Address of Facility}
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd. Baltimore, MD 21212 21. Signature of Funeral Service Licensee John O. Mitchel Approximate Interval Between Onset and Death 23a. 14.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SCPSI Due to (or as a consequence of): neumonia Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner** Physician/Medical Examiner

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physician the

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certificate Physician:

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hours after death uneral Director:

within 2 o the F

or Attending

funeral director,

filled in 24 hours a

Completed by

Be

Certification: To

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Director

Be Completed by

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 2 No

26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

28b. Time of

1 ☐ Yes 2 ☑ No 27. Manner of Death

6 Could not be determined

25. Was case referred to medical examiner?

28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

29b. Signature and title of certifier Cynthia Smano Mo 29c. License number D0051347 29d. Date signed (*Month*, *Day*, *Year*)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthiu Soriano MD 6701 N. Charles St. Baltimure MD 21204

Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 10b, 19b, perFH, 6870, 8/20/07 TCertificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 16 Ziti V /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner unbis on berent If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 62 Days Hours Min. 1 M 2 □ F 213-46-4772 12/07/1944 MD **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at Howard 1 ☐Yes 2 No Director ANNE ARUNDEL **JESSUP** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8061 ROUND MOON CIRCLE 20794 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □ Yes 2 💢 No Specify: WHITE Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE CITY POLICE College (1-4or 5+) Elementary/Secondary (0-12) the DEPARTMENT POLICE OFFICER s 1 and 2 should be filed wi f Health and Mental Hygien Item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HILNBRAND HILNBRAND DAVID LUCILLE ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8061 ROUND MOON CIRCLE - JUSSUP, MD 20794 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any injury or other trau once. JUDY HILNBRAND / WIFE 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' PROGRESSIVE RUDOMER 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 08/19/2007 ROSEDALE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Ent if the rise ise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or reart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) the scleone CNOW VASCULA **Physician** /Medical Due to (or as a consequence of) Examiner -schenic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760 physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for 1 in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed peen olesterol 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s performe certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **₩**0 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To funerai 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 □ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif

To the Hospital within 24 hours a To the Funeral E

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signatur

AUG 2

30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	-		ificate of L			Reg. No.	2007	26627
F	Physicia	an l	1. Decedent's Name (First, Middle, Last)						2. Date of Dea	ath Day	Year	3. Time of Death
	/Medic		Donald	s.	Нас	ldaw			_	5, 2	007	5:15p ^M
	Examin	er	4a. Facility Name (If not institution, give sti Mallard Bay Nursin					Location of Death		4c. Q	County of Death Dorches	ter
	Funeral Director		217 10 3000	7. Age M 2 □ F	(In yrs. last birt	hday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) 12/16/	h y, Yea <i>r)</i> 1912		nplace (State or Foreign untry) ryland
	tryland show 1 at	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loca	ation					10d. Inside City Limits
	he Ma 18a-f s	Director	MD. Dorcheste	r	Secreta	ary	404 75- 0-4-			10- Citi-	en of What Cou	1 ☐ Yes 2 ☐ No
	th with t 23a or 2 Ist be n	af Dir	10e. Street and Number P.O. Box 383				10f. Zip Code 21664				SA	unity :
000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 12 1 ✓ Never Married 2	2. Was Decedent Ender Armed Forces? 1 ☐ Yes 2 ☑ Note of the Section of the Secti		1	as Decedent of Hi Yes, specify Cuba □ Yes 2 12 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		4. Race - Amer Black, White Specify: W	
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B	الگرانية		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused to cause on each line	he death. Do n	not ente	r the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
8	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Arterio.			Heart	Discole				Onset and Beatin
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0.00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	lc. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death		Ectopic pregnancy Other (specify)			2	3d. Date of deli Month	ivery Day Year
,	s that ined by e deta	by Ph	Part II. Other significant conditions cont		-		derlying cause give	en in Part I.	23e. Did t	obacco us	se contribute to	the cause of death?
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בים וו	The law rate has be page 2 sh	Completed							24a. Was autop perfo 1∐ Yes	osy ormed?	24b. Were au prior to death? 1 ☐ Yes	topsy findings available completion of cause of
V 1.0	ician: certific ector,	Be	25. Was case referred to medical examiner?	ospital:			LOthe	26. Place of Deat				
5	y Phys er this eral dii	To	27. Manner of Death	28a. Date of Injury	/ 28b. 7	Time of	3∐ DOA 28c. Injur Worl	er: 4 Nursing Ho	me 5 Resi	dence 6 how injury	Other (Spec occurred	cify)
5	ath. or: After	atior	1 ☐ Natural 5 ☐ Pending investigation	(Month, Day	Year) II	njury		Yes 2 ☐ No				
	al or Att s after de il Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injut building, etc.	y - At home, far (Specify)	rm, stre	et, factory, office		28f. Location (City or To	Street and wn, State)	d Number or Ru)	ıral Route Number,
	e Hospit 24 hours e Funera letely fille	Medical C	29a. Certifier (Check only one) Certifying Physic Certifying Physi	ician: To the best o er: On the basis of and manner stat	examination an	e, death d/or inv	occurred at the tir estigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
	To the within To the Complex C	Me	29b. Signature and title of certifier	Lan	Mn		29c. License				e signed (Monti	
1	9		• la	July 1				7924		8	-17-0	
5) [30. Name and address of person who con NOMAN - THROUGH	mpleted datase of de	ath (Item 23a) (Type, F	rint)	RIBGE	40	21	613	
di	Sta Registr	_	31. Date filed (Month, Pay, Year) AUG 2 0 20	32. Registra	r's Signature	le le	ade					

Physician /Medical Examiner

r 28a-f show notified at

"natural", or items 23a or

Pages 1 and 2 should be filed within 72 hours after death

altimore, Maryland 21215-0036

attending physician and for use as the burial-tran signed by the a d be detached for this certificate has al director, page 2

Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

State Registrar

Certification: Medical

29b. Signature and title of certifier

Than BON, MD, FACE

and manner stated

D 51088

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thow Poon 301 ST. Raw Planu ST. Ram Than Poon

Bartimou, MD 21202 #701

18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

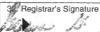
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

AUGUST 16, 2007

31. Date filed (Month, Day, Year)

29a. Certifier

AUG 2 0 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #10e,14,17,18state of Maryland Top before the arth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician August 8, 2007 Paul Howe 5:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Prince George's Medical Center Cheverly Prince George's 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Unk 5. Social Security Number 6. Şex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1₩ 2□F Director 039-28-7117 July 8, 1945 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and the flam 27 is marked other than "natural", or items 23a or 28a-f show ant; if Item 27 is marked other than "natural", or items 28a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director Prince George's MD Lanham 10e. Street and Number 6217 Brightlea Dr. 10g. Citizen of What Country? 10f. Zip Code 20706 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. White 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: - b1 Specify: þ 3 ☐ Widowed 4 🛣 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Be Morris Howe, Jr. ျှ Alma Ann Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Shryock-Hesson / Friend 6217 Bright Lead Drive Lanham, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 3 □ Cremation 3 □ Removal from State Department or Important: If any Injury or once. Wesleyan Chapel Cemetery 9/19/2007 Havre De Grace 22. Name and Address of Facility Renders have Fineral Hone Street 21. Signature of Funeral Service Licensee Ronald S. Wades Director Ball Apparollis Rd Lapham, MD 20706 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat, ry arrest, shock, or heart failure. List only one cause on each light year. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to ker as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner enn physician and s the burial-trans Division or Vital Records, P.O. Box 68760 Physician/Medical as nse (IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an funeral director, page 2 autopsy 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 3□ DOA 1 ☐ Yes 1 Inpatient 2 ER/Outpatient Medical Certification: To 27. Manner of Death 28a (Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month Day, Year) ss of person who completed cause of death (frem 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

3001

32. Registrar's Signature

HOSPITAL DRIVE

CHEVERLY

CATEVENIS

07-05975 Hope Elaine Issa

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State of Maryland / Department of Health and Mental Hygiene	6 1	

			1- For State Certificate of Dea	ath Reg. No.
	Physicia		1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year 1102 bro
V	al Exami		Hope Elaine Issa	August 4, 2007
				r, Town, or Location of Death 4c. County of Death
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	Funeral		or cooking realized that the cooking realized the c	nder 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
	Director		1 M 2 X F 45 Yrs.	Aug 13, 1961 Country) Ohio
7		İ	Usual Residence of Decedent	
	any		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	nd Show	칟	MD Baltimor	e 1 X Yes 2 No
adre .	Maryland 28a-f show any d at once.	핥	10e. Street and Number 10f. 2	Zip Code 10g. Citizen of What Country?
	the M	Director	2411 E. Biddle Street	21213 USA
	with the Maryland ns 23a or 28a-f sho be notified at once	ā	11. Marital Status unk 12. Was Decedent Ever in U.S. 13. Was Dece	edent of Hispanic Origin? (Specify Yes or No- acify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
	leath r iten	Funeral	1 Never Married 2 Married Armed Forces? If Yes, spe	ecify Cuban, Mexican, Puerto Rican, etc.) White, etc.
	after o	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes	2 X No specify: Specify: white
	136 thin 72 hours aftere. te. than "natural",	9	15 Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usu	ial Occupation (Give kind of work done unk 16b. Kind of Business/Industry unk working life. DO NOT use retired)
	72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	indianing into 20 the restriction
	5-0036 iled within 7 Hygiene. I other than the Medica	립	8 0	
	5-0(fled wir Hygier flother the M		17. Father's Name (First, Middle, Last)	unk 18. Mother's Name (First, Middle, Maiden Surname) unk
	2121 ould be fil Mental F marked ic event,	å	Lage Marillan Address	ess (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland cent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner.	٤	1,1,1	
	e, MD 2 1 and 2 shou Health and N Fitem 27 is u	ŀ	O.C.M.E. 111 Per	nn Street Baltimore, MD 21201 Name of cemetery. Date 120c, Location - City or Town, State
	TOFE, ages 1 a mt of He tit. If ite other ti		1 Burial 2 Cremation 3 Removal from State crematory or other pla	
	Page ment tant:		4 Donation 5 X other Specify: in state	
	Baltimore, permit. Pages I an Department of Hea Important: If ite	1		Anatomy Board 655 W. Baltimore Street
		4	23a. Part/I. Enter the disease, or complications that caused the death. Do not enter the modern that the modern that caused the death.	more MD 21201 de of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
	Physician Medical		failure. List only one cause on each line.	Death Death
	examiner		Immediate Cause (Final disease or condition resulting in death) A Mixed alcohol and drug (morphi	ine) intoxication
			or condition resulting in death) Due to (or as a consequence of):	
		ē	Sequentially list conditions, If any, leading to immediate Duo to (or as a non-sequence of):	
		Examine	cause. Enter Underlying Cause (Disease or injury that initiated C.	
/	d d	Xa	events resulting in death) Last Due to (or as a consequence of):	
/	760, icate be executed physician and the burial - transit		d.	
•	be ex sician	/Medical	XUNPENDED AMENDED AMENDED 27,28a-f, perME,g870,	8/22/07 TI
	760, ficate be g physic the burn		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea	23d. Date of delivery ath 3 Ectopic pregnancy Month Day Year
	Box 68 e death certif the attending ed for use as	siciar	past 12 months? 4 Pregnant at time of death 5 Other (\$	
	30x death le atte	ysi	1 Yes 2 No 9 V Unknown 9 Unknown	
	, P.O. Box 68 ires that the death certif signed by the attending be detached for use as	, Phy	Part II. Other significant conditions contributing to death but not resulting in the underly	
	P. es that ignect be de	d by		1 Yes 2 No 3 Probably 4 Unknown
	ds, requir	Completed		24a. Was an 24b. Were autopsy findings available prior to completion of cause of
	tal Records, cian: The law requirectificate has been sector, page 2 should	ldπ		performed? death?
	Re The ficate , pag	Col		1 ✓ Yes 2 No 1 ✓ Yes 2 No 26.Place of Death (Check only one)
	tal ician: certi	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3	DOA Other's Nursing Home 5 Residence 6 Other:
	f Vit Physic er this ral dir	To	1 ✓ Yes 2 No Impatient 2 ✓ Produpation 3 27. Manner of Death 28a. Date of Injury 28b. Time of Injury	28c. Injury at Work? 28d. Describe how injury occurred
	ding Pl	on:	1 Natural 5 Danties (Month, Day, Year)	1 Yes 2 w No
	SiOl otten death ctor:	ati	Investigation Find 8/4/200/ Find 10:16 a	1111
	Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rs after death and Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 X Could not be determined (Specify) found in all ov	or Town, State)
	Division Hospital or Attenc 24 hours after death Funeral Director: tely filled in by the	Cel	4 Homicide Tourid III alley	2411 E. Biddle St. Baltimore, MD
	Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	cal	Check only 1 Certifying Physician: To the best of my knowledge, death occurred a cone 2 Medical Examiner: On the basis of examination and/or investigation, in	t the time, date and place, and due to the cause(s) and manner as stated. n my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the within 2 To the complete	Medical	and manner stated.	29c. License number 29d. Date signed (Month, Day, Year)
		Z	29b. Signature and title of certifler	O.C.M.E. August 5, 2007
			-410 (AV/)	August 0, 2007
			30. Name and address of person who completed cause of death (Item 23a)	troot Paltimoro MD 24204
			.07	treet, Baltimore, MD 21201
	S Regis	tate	13 1 1 m 1 % / 13 1 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2 /	

07-06092 Ronald Johnson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2007 25631

		- For State Certificate of Death									Reg. No. 2. Date of Death 3. Time									
Physician Lectical Examine	/ 1	1. Decedent's Name (First, Middle,Last)												eath Day 3, 200	3. Time of Death 1710 hrs					
<i>></i>	4	la. Facility Name (if		tion, give street and number) Ve				4b. City, Town, or Location of Death Abingdon							4c. County of Death Harford					
Funeral	5	5. Social Security N	umber	6. Sex		7. Age (In yrs. last birthda			7. Age (In yrs. last birthday)						24Hrs. Min:	8. Date of	Birth(M	M/DD/YYYY	Foreig	
Director		254-98-30	504	1 X M	2F		52	Yrs.			=4		Feb :	21,	1955_		Georgia			
,	_	Jsual Residence of 10a. State	Decedent 10b. County			10c. C	ity, Town o	r Locati	on								10d. Inside City Limits			
ow any		MD	Harf	ord				ingd									1 Yes 2 X No			
Maryland 28a-f show d at once.	٦	10e. Street and Nur			10f. Zip (Code				10g. (Citizen of Wh	at Cou	intry?							
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shour ite event, the Medical Examiner must be notified at once	Director	3105 Whi		c Dri	Lve					210	009				USA					
with the s 23a		11. Marital Status 12. Was Decedent Ever in U.S					n U.S.	13. Wa	s Deceder	nt of Hisp	anic Origi	n? (Spe	cify Yes or	No-			rican Indian, Black;			
death or item	Funeral	1 X Never Marrie	ed 2 N	larried	Armed F	orces?	0		es, specify			Puerto R	(Ican, etc.)		White, etc.					
after	ᇫ	3 Widowed	-	0	Yes, Give Ye r Dates:				Yes 2					1.0	Specify:		hite			
hours afte "natural", Examiner		15. Decedent's Ed					1) 16a. D	eceden uring m	t's Usual C ost of worl	Occupation king life. I	on (Give k DO NOT u	ind of wo	ork done ed)	161	b. Kind of Bu	siness	/industry			
5-0036 ed within 72 hours after tygiene tygiene "natural", the Medical Examiner	Completed	Elementary/Seco	ondary (0-12)			(1-4 or 5+)	l l	000	rais	0.75					jewe	alrı	57			
5-0036 ed within 7. tygiene. other than	Ē -	12 17. Father's Name	Eirst Middle	a Last)	4			арр	lais		8.Mother's	s Name (First, Middl	e, Maid	len Surname		ž			
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be	Elwood	•								Alio	e Se	edlita	zki						
212 212 wild be Ments mark		19a. Informant's Na			e, Print)		19b	Mailing	g Address	(Street					, City or Tow	n, Stat	te, Zip Code)			
MD nd 2 sto alth and 27 is		Bobby Jo	hnson	/bro	ther		10)4 R	lobin	Spr	ings	Road		ıvi1	le, T	N 3	7220			
Healt ife		20a. Method of Dis		- 0	Domousli	I .	0b. Place of cremato		sition (Nam her place)	ne of cem	etery,		Date	20	oc. Location -	- City o	or Town, State			
mor Pages ent of nt: 1		1 Burial 2 4 Donation 5																		
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If iten 27 is marked other thinjury or other fraum; it event, the Med	1	Donation 5 21. Signature (Fu	neral Service	e License	200	hiroct	or	22. N	Name and	Address	of Facility	nard	655	IAT 1	Raltim	ore	Street			
E E E E		Hen	\mathcal{M}	16		ee-	01	Ra	ltimo	re.	MD :	2120					Approximate Interval			
Physician		23a. Part I. Enter the failure. List or	ne dise é se, é ily one caus	e on each	n line.					or ayıng, s	such as ca	ardiac or	respiratory	arrest,	SHOCK, OF THE	art	Between Onset and Death			
aminer		Immediate Cause or condition resulti		_		erotic Card		ar Dis	ease	_							-			
	1			b.	Je to (or as	a consequent	ce ory.													
	ē	Sequentially list of if any, leading to in cause. Enter Und	nmediate		ue to (or as	a consequen	ce of):													
	Examiner	(Disease or injury events resulting in	that initiated	٠. -	ue to (or as	a consequen	ce of):					`								
				d						_										
8760, ificate be executed ig physician and is the burial - transit	Physician/Medical	UNPENDE)		AMENDED)														
8760, ifficate bung physical as the bung	§ [IF FEMALE: 23b. Was deceden	pregnant in	the		s, outcome of p			etal death	3	Ectopic	c pregna	ncv		23d. Date o Month	f delive	ery Day Year			
P.O. Box 68 s that the death certify greed by the attending detached for use as	cial	past 12 month		9		gnant at time o	of death 5		ther (Spe			P S								
Box 68 e death cert the attendir ed for use a	ysi	1 Yes 2		nknown		nown											to the control of death?			
P.O.	Y P	Part II. Other sign		litions (contributing	to death but r	not resulting	g in the	underlying	g cause g	iven in Pa	art I.					to the cause of death?			
S, P nires that signs a signs of the d	pa pa	Alcohol Al	ouse										1000	Vas an	100.000	12-7-1	autopsy findings available			
cords, P.O. law requires that has been signed b	Completed by												a	utopsy			o completion of cause of			
Reco	E													es 2		1 🗸				
tal Rec	Be	25. Was case refe examiner?	rred to medic	_	anital:						of Death Other					- 4 04				
hysic al dire	P	1 🗸 Yes	2 No	Inc	ospital:	Inpatient 2		utpatier Time of			ry at Work		g Home 5		esidence 6		ner: Scene			
n of ding Ph		27. Manner of Dea1 ✓ Natural		nding	Z8a. Da (Moi	ite of Injury nth, Day,Year)	200.	Time of	injury		Yes 2	- I	200. 2000		,,					
Sion Attend r death. ector: by the f	cati	2 Accident		estigatio	n	ace of Injury -	At home fa	arm str	eet factor	-			28f. Locati	on (Str	eet and Num	ber or	Rural Route Number, City			
Division of Vital Records, pital or Attending Physician: The law requirours after death. eral Director: After this certificate has been stilled in by the funeral director, page 2 should I	Certification:	3 Suicide		ould not b termined	e Specif		7 tt (10th) (1	2.,,, 00.		,,	3,		or Tov	vn, Sta	te)					
ie o iii		4 Homicide 29a. Certifier (Check only	Certifying	Physicia	n: To the h	nest of my kno	wledge, de	ath occi	urred at th	e time, da	ate and pl	ace, and	due to the	cause(s) and mann	er as s	tated.			
To the Howithin 24 h	Medical	one) 2	Medical E	xaminer:	On the bas and manne	is of examinat	ion and/or i	nvestig	ation, in m	y opinior	n, death of	ccurred a	at the time,	date an	d place, and	due to	the cause(s)			
To William	Me	29b. Signature an	title of cert			//			29		e number						Month, Day,Year)			
		O.C.M.E. August 9, 2007								/										
		30. Name and add						4			41	MD	1004							
		Jack Titue						11 Pe	enn Stre	et, Bal	timore,	MD 21	ŧ∠U1							
St	ate		nth Day Yes	0 2	007 32.	Renistrar's Si	gnature	A	mark											

			1 - For State Røgistrar	State of Ma	aryland		artment of F		and M		giene Reg. No.	007	26632
	Physici	an	1. Decedent's Name (First, Middle, Las							2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medio		Casimir Kamin							7	3/	2007	0:32 AM
7	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, o	*	of Death		4c. (Bal4.	
			Tenis's Perning 5. Social Security Number 6. S	Varkwey	e (In yrs. las	t hirthday)	If Under 1 Year		24 Hrs.	9 Date of Birt	<u> </u>		
	Funeral Director		1	XM 2□F	79	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day 05/15/	1 928		thplace (State or Foreign ountry)
	ס		216-24-3822 Usual Residence of Decedent									L'ICL	*
	urylan show	_	10a. State 10b. County		10c. City, 7	Town or Lo	cation						10d. Inside City Limits
	Ba-1 s	Director	Maryland Baltimo	re	Park	ville							1 ☐ Yes 2 ☐ No
	with th	Dire	10e. Street and Number 10f. Zip Code									en of What C	
	s 238	eral	1801 Wentworth Ro	ad 12. Was Decedent	Ever in II S	13 1	21234 Was Decedent of H	lienanic Ori	gin2 (Sp	ocity Ves or No-		ted Sta	
	item de	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces?		13.	f Yes, specify Cuba	an, Mexicar	n, Puerto	Rican, etc.)		Black, Whi	te, etc.
980	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f show the Model Exerter from the Model Exerter of the Model Exerter	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		52	1□Yes 2XXNo	Specify:				Specify: W	nite
21215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced	ient's Usual Occup	ation during mos	t of work	na	16b. Kin	d of Business	/Industry
7	ithin "ee".	nple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT use retired	d)					
	filed w Hygier Sther th	Col	8 17. Father's Name (First, Middle, Last)			Facto	ory	10 Moths	r'a Name	(First, Middle,		omotive	e
Maryland	ntal Hed of	Be									maiden s	ourname)	
Ž	should be nd Mental marked o	은	Casimir Kaminski 19a, Informant's Name/Relationship	voe Print)		19h Mailir	g Address (Street			Shank	er City or	Town State	Zin Code)
Ma	id 2 s lith an 27 is i		Helen Kaminski -				V. Tidewa						
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other treumatic event. The Modeal Examination that an once.		20a. Method of Disposition	naugitter	20b. Plac	en of Dispo	sition (Name of	3		ate		cation - City or	
Ë	Page ent o nt: if ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specifi			Cemet	alone other play	esus	8-1.	3-07	Ral+	imore.	Maryland
Baltimore,	mit. I partm portei / Inju		21. Signatore of Funeral Service Licen			22	. Name and Addre		ty			INOIC,	- Carlot
m	Depa Impo any ir		Flueie K_	X		Tt	nomas J. 329 Hudso	Skard n Str	a Fu eet	neral H Baltimo	ome re.	Marvla	nd 21224
J			23a Part 1 Enter the disease, or companies shock, or heart failure. List only	olications hat caused one cause on each li	the death.							4	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ASCU	ο.								Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):							0
	LAdiminei	_	Sequentially list conditions,	b. Due to (or as	2 0000000000	non of):							
	ted	nlne	if any, leading to immediate cause. Enter Underlying	200 10 (01 43	a consoque.	1100 01).							
,	axecu n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequer	nce of):							
8760,	eath certificate be executed attending physician and for use as the burial-transit	dical		d									
9		Medi	15.55141.5										
Box	th cer tendir ir use	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1☐Live birth	of pregnanc	y eath 3□	Ectopic pregnancy	,			2	3d. Date of de Month	olivery Day Year
	e dea the at ned fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of deat	th 5 ☐	Other (specify)					WOTH	Day Toal
P. 0.	The law requires that the death certific ste has been signed by the atlending p page 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions c	antributing to death b	ut not resulti	ing in the u	nderlying cause giv	en in Part I		23e. Did to	obacco us	se contribute t	to the cause of death?
ds,	w requires that been signed be should be det	d by	Demenha	g			, , , , , , , , , , , , , , , , , , ,			1 🗆 Y	/es 2□]No 3□P	robably 4 Munknown
Sor	v requ	lete								24a. Was	an	24h Were a	utopsy findings available
Re	he fay s has ge 2	mp	Hend insufficency							autop perfo	sy rmed?	prior to death?	completion of cause of
g	ificate or. pa	e Cc	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes	2 2 No	1 LJ Ye	s 2 No
>	Physicien: r this certific ral director,	To B	examiner?	Hospital:	ent 2 EF	VOutpatien	t 3 DOA Cth	05	11600	me 5 ☐ Resid		Other (Spe	ecify)
10	ding Physicien: The lav h. Atter this certificate has funeral director, page 2		27. Manner of Death	28a. Date of Inju (Month, Da	ry 28	8b. Time of		1000		28d. Describe h			,
Ö	andin ath. or: Aft	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		, , , , ,	,ary		Yes 2	No				
Division of Vital Records,	i or Attendatter deatl	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home c. (Specify)	e, farm, str	eet, factory, office			28f. Location (S City or Tox		l Number or F	Rural Route Number,
Ω	oitel ours af			1									
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	edical		ysician: To the best iner: On the basis o and manner st	f examination								
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner su	2100.		29c. Licens	e number			29d. Date	signed (Mor	nth, Day, Year)
	ν 3 + 3 + 3		111111 12	100-			P3/	291-			G.	1.107	
0	7		30. Name and address of person who	completed cause of d	leath (Item 2	За) (Туре.	Print)				0 /	, , ,	
5	,		Wends Kloesz ,	no 670	1 H	Chas	Us St S	inte	43	102 7	e wson	~ m	rd Discy
	Sta		31. Date filed (Month, Day, Year)	32 Registr	ar's Signatur	P	us St S						
	Registr	ar i	1 10 U Z (1 Z)	O I	-	10							

		-	For State State Registrar	of Maryland		rtment o <i>tificate</i> d				iene eg. No. 🧷 🏻	ñ.7	25633		
Ì	Physici	_	1. Decedent's Name (First, Middle, Last) Peg Kloes						2. Date of Deal		J ^{Year}	3. Time of Death 7:15 a M		
)	/Medic Examin		4a. Facility Name (If not institution, give street and Gilchrist Center		4b. City, Tow	n, or Locatio ພຣວກ	on of Death		4c. County of Death Baltimore					
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑	7. Age (In yrs. las	st birthday)_ Yrs.	If Under 1 Y Months Da		ler 24 Hrs. s Min.	8. Date of Birth (Month, Day, May 15,	1946	9. Birthp	place (State or Foreign ofty) and		
	aryland show d at	J.	Usual Residence of Decedent 10a. State 10b. County		Town or Loc						1	I0d. Inside City Limits 1 ☐ Yes 2 No		
	y with the M 3a or 28a-f st be notifie	Funeral Director	MD Baltimore 10e. Street and Number 24 East Seminary Avenue		-u cher	10f. Zip Co	de 11 093		1	0g. Citizen of				
36	s after death ", or items 2 aminer mus		1X Never Married 2 Married 1 1 Yes	Decedent Ever in U.S. d Forces? 'es 2 No s, Give or Dates:		/as Decedent Yes, specify			ecify Yes or No- Rican, etc.)	14. Ra Bla Speci	ce - Americack, White,			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle	ted)ge (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary School Teacher					16b. Kind of Business/Industry Baltimore County				
and 21	t be filed wintal Hygien ed other the event, the	Be	17. Father's Name (<i>First, Middle, Last</i>)	+ Kloes	CTEME	illary	18. Mc		e (First, Middle,	_		0012		
Maryland	nd 2 shoulk alth and Me 27 is mark r traumatic	ပ္	19a. Informant's Name/Relationship (Type. Print, Beth Seeley-partner						al Route Number Lutherv			o Code) 1093		
Baltimore,	Pages 1 a nent of Hea int; If item iry or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal 1 4 □ Donation 5 ☒ Other (Specify) Enton	rom State cer	metery, crem	ition (Name of atory or other	of r place)	8/20	Date 0/07	20c. Location	•			
Balti	permit. Departn Importa any inju	e ne	21. Signature of Funeral Service Licensee Wi	lliam G. Da	au ^{22.}	Name and A	rk Rd	., Tou	uson, MD					
	Physician		23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	LUNG	CAN		dying, such	as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death MON77/5		
300	/Medical Examiner	er	Sequentially list conditions b.											
98760,	cate be executed physician and the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d												
.O. Box 68	w requires that the death certifica been signed by the attending ph should be detached for use as t	Physician/Med	in the past 12 months?	s, outcome pf pregnan Live birth 2 ☐ Fetal o Pregnant at time of dea Unknown	death 3 🗌	Ectopic pregi Other <i>(speci</i>					Date of deliv	very Day Year		
₽.	quires that n signed by uid be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.									ute to the cause of death?		
II Reco	The lavate has	Completed by	COPD							an 24t osy rmed? 2000	Were autopsy findings available prior to completion of cause of death? □ Yes 2 □ No			
or Vita	Physician; Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2010 Hospital:	1 ☐ Inpatient 2 ☐ E	R/Outpatient		Other: 4			dence 6		ity) HOSPICE		
Division or Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:										ral Route Number,		
Ö	Hospital or & 24 hours after Funeral Directed in bite stelly filled in b		29a. Certifier (Check only 2 Medical Examiner: On	the basis of examination	rledge, death				, and due to the	cause(s) and				
	To the I within 24 To the Complet	Medical		manner stated.		29c. L	icense numb	395		29d. Date sig	ned (Month	7, 2007		
_	207		30. Name and address of person who completed		23a) (Type,	Print) N.CHA	eises	T, SL	LITE 216	, Tows	ON M	p 21204		
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure	barle	- 00							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARJORIE S. KUEHNE AUGUST 18, 2007 8:58 A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TOWSON BALTIMORE HOLLY HILL MANOR NURSING HOME If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 TF Yrs. 93 Director 578-03-4217 1/4/1914 WASHINGTON D.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be prafified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director MD BALTIMORE PERRY HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 USA 14. Race - American Indian, 4300 CARDWELL ROAD 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HOWARD R. SMITH JOSEPHINE C. JOHNSON စ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM E. KUEHNE/SON 13911 FOX LAND RD. PHOENIX, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State DULANEY VALLEY MEM. 8/21/2007 COCKEYSVILLE, MD 4 Donation 5 Other (Specify) GARDENS me and Address of Facility 21. Signature of Funeral Service Licensee THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cardiovascular disease **Physician** Atheroscleration years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. burial-tran aftending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 □Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

State

To the Hospital within 24 hours a To the Funeral D

Medical

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Inna Gendelsman

AUG 2

DHMH 17 Rev 1/2001

Registrar

york Rd

endeltwan M.D.

1205 32. egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D0057454

29d. Date signed (Month, Day, Year)

5-38, Lutherville, MD 21093

		Please	Type or Prin						egible.	
		For State	State of Ma	-	epartment of I		Mental Hyg	jiene		00000
		1 State Registrar 1. Decedent's Name (First, Middle, La	not)	C	Certificate of	Death	2. Date of Dea	eg. No.	UUI	3. Time of Death
Physic	ian	Patricia	151)	Kosc	ielski		Month	16, Day	Year	11:15 P M
/Med		4a. Facility Name (If not institution, given	ve street and number)			or Location of Death			ounty of Death	
Exami	ner	911 Rosedale Aven			Rosed				ltimore	ž
Funeral Director		5. Social Security Number 6.		e (In yrs. last birtho	(ay) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day January 8	Year)	9. Birthp	place (State or Foreign
- 12A 14F		Usual Residence of Decedent		12			partially 0	, 1555	Plot y.	Laria
ryland how		10a. State 10b. County		10c. City, Town o	r Location				1	0d. Inside City Limits
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or 28	Dire	10e. Street and Number			10f. Zip Code		1	-	n of What Cour	ntry?
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone.	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexican, Puerto			pecify Yes or No- Dican, etc.) 14. Race - Amer Black, White Specify; Wh:		
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uld be file Mental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Las John Evans	")			18. Mother's Nam	ne (First, Middle, i a Cumbe		,	
12 sho		19a. Informant's Name/Relationship	(Type. Print) Husband	1	Mailing Address (Stree Rosedale					,
T and 1 and Health em 27 ther tr		James Koscielski 20a. Method of Disposition	nusband						tion - City or To	
Pages nent of h		1 🕅 Burial 2 □ Cremation 3 🛭			isposition (Name of crematory or other place of Jesus	. Auu	. 21		lk, Maryl	
iit. Partme		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		Jaca Carl			2007		• -	
permir Depar Impo any ir		1 Lithous	(onn	of ly	Connelly F	funeral Ho ers Point	ome Of Di Road Di	undal	K,P.A. k.MD 2	1222
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be exection a	11-	resulting in death) Last	Due to (or as	a consequence of)	:					
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		230	d. Date of delive Month	ery Day Year
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nysic nis ce direc	일	1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outp	atient 3□ DOA Ot	her: 4 🗌 Nursing H	ome 5 Resid	ence 6[□Other (Specif	5y)
ding Physician: The land. After this certificate he funeral director, page		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da			ıry at ork?	28d. Describe h	ow injury o	occurred	
tor: A	Sati	2 ☐ Accident investigation]Yes 2 □No				
or Att fter d Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	20e. Place of Inj	ury - A t home, farm c. <i>(Sp</i> ec <i>ify)</i>	n, street, factory, office		28f. Location (S City or Town	treet and f n, State)	Number or Rura	al Route Number,
pital urs a eral [202 Cortifier 1 Continue 2	hysician: To the best	of my knowledge	death prouved at the	time data and also	and due to the	nouse (a)	ad manas -	totod
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: K completely filled in by the the	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	miner: On the basis o and manner sta	f examination and/	or investigation, in my	opinion, death occu	r, and due to the d urred at the time, o	date and p	lace, and due t	o the cause(s)
othe other omple	Me	29b. Signature and title of certifier			29c. Licen	se number	2	29d. Date s	signed (Month,	Day, Year)
F > F 0		10000				/				

DHMH 17 Rev 1/2001

State

Registrar

Daniel Collector, MD. 35 East Padonia Road, Timonium, MD. 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG1 8 2007

31. Date filed (Month, Day, Year)

07-05999 Robin Lemmon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1237 hrs August 5, 2007 ≺l Examiner Robin Lemmon 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore St. Agnes Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 7. Age (In vrs. last birthday) 5. Social Security Number unk 6. Sex **Funeral** Days Country) Director Aug 13, 1954 1 M 2 X F 52 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No 23a or 28a-f show notified at once. Baltimore Halethorpe Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 3065 Freeway 21227 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status pe If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? unk Never Married 2 must Yes Yes. Give Yea Yes 2 X No specify Specify 4 X Divorced white Widowed item 27 is marked other than "natural", tranmatic event, the Medical Examiner ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 hours. Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 clerical insurance 1111 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Clayton Lemmon Helen O'Donnell Be of Health and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21015 19a. Informant's Name/Relationship (Type, Print) O.C.M.E. Donald Lemmon/brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Baltimore, crematory or other place) t: If i Removal from State Burial 2 Cremation 3 permit. Page
Department o
Important:
injury or oth Donation 5 X Oner Specify: 22 Name and Address of Faci State Anatomy 21. Signature of Funeral Service Licensee Ronald S. W Board 655 W. Baltimore Street ector 21201 Baltimore, MD Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval ^Dhysician Between Onset and List only one cause on each line Death fledical Henorrhage Immediate Cause (Final disease .xaminei or condition resulting in death) Due to (or as a consequence of): Ruptured atherosclerotic aneurysm of the splenic artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed hysician/Medical **11,15–19b** 7.perME.g871 X UNPENDED the attending physician ed for use as the burial Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day Ectopic pregnancy past 12 months? Pregnant at time of death Other (Specify) 5 signed by the atte 1 Yes 2 No 9 V Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an page 2 should been autopsy prior to completion of cause of death? certificate has performed? 1 🗸 Yes No Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical of Vital director, Be Hospital: 1 Other₄ Residence 6 2 V ER/Outpatient 3 DOA Nursing Home 5 Inpatient After this ٩ 1 Yes funeral 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 27 Manner of Death Certification: 1 X Natural Division 1 Yes 2 No Pending within 24 hours after death.

To the Funeral Director: the 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME August 6, 2007 OCME 30. Name and address of person who complete course of death (tem 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD 32 Registrar's Signature 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 1/2001 OCME 2006

Registra

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Mary Elizabeth lager 11:54 p.M August 16, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Olney Montgomery Montgomery General Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) November 22, 1917 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1 □ M 2 X F 89 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 No Fulton Maryland Howard Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20759 U.S.A. 11788 Rt. 216 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ever No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. Š White 3 Widowed 4 ☐ Divorced the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College 1-4or 5+) Own Home Homemaker If item 27 is marked other or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Frank Neville Stauffer Ethel Mae Zimmerman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8115 Murphy Rd. Fulton, Maryland 20759 Mr. Charles lager Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08/22/07 Department o Important: If any Injury or once. Fulton, MD St. Paul's Lutheran Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Service Licen bumbella. MUD530 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final disease or condition resulting in death) **Physician** Adenocaro /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner and burial-tra Due to (or as a consequence of) attending physician Physician/Medical the as for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the a 9 Unknown þ signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Antray Dispuse Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has , page 2 autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 20 No 1 Impatient 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

requires that the death certificate be executed Box 68760, P.O. Division or Vital Records, within 24 hours after death.

To the Funeral Director: After this Hospital or Attending completely

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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State Registrar

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

ARTHUR Filoodurand In 3416 Olandwood Ct. Olney Haryland 20832 31. Date filed (Month, Day, 32. Régistrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month Year David Robert Leonard 2007 August 15, 8:20 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3337 Kensington Square Manchester Carroll 6. Sex XXM 2□ F If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Yrs. 69 **Director** 220-36-4122 Aug. 11, 1938 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 □Yes XXNo Director Maryland Carroll Manchester 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be Ŭnited States 3337 Kensington Square 21102 America death Funeral 12. Was Decedent Ever in U.S. Armed Forces? **Example States and The States are states and the States are states are states and the States are Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Maryland 21215-0036 YYes 2□ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th President Uniform Company Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, i once, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Joseph Mason Leonard F. Jane Grigor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon L. Leonard (Wife) 3337 Kensington Square; <u>Manchester, Maryland 21102</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Aug. 17, XXBurial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) Dover Church Cem. 2007 4 □ Donation Upperco, Maryland 21. Signature of Fureral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, MD 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician ساومه /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as attending properties of the pr IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a P.O. 9□Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 4 betes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 No I or Attending Physician: after death. 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 nesidence 6 Other (Specify) P 27. Mann f Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation neral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

V.X

To I

31. Date filed (Month, Day, Year) State Registrar AUG 2 0 2007

30. Name and

29b. Signature and title of certific

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150 MAKN 1~100W 2. Registrar's Signature

ddress of person who completed cause of death (Item 23a) (Type, Print)

Reiskinting, with 2/18

29d, Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Year **Physician** Ε. 17 10:00 a M Lutz Aug. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bon Secours Marriottsville Howard 8. Date of Birth (Month, Day, Year) 12–10–1917 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 X F 89 165-10-8842 Pa. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 No Director PA. Delaware Darby 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 should be filed within 72 hours after death with and Mental Hygjene.

Is marked other than "natural", or items 23a or st 520 Pine Street 19023 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 2 2 3 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 2 Specify: white 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) manufacturing candy maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Kane Anna O'Leary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum once. Bonnie Lutz daughter 12433 Cape Cod Drive, Creve Coeur, MO 63146 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8-23-2007 Yeadon, PA 19050 Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling, Ashton Schwab Witzke F.H. of Catonsville, Inc., 1630 Edmondson Ave., Catonsville, Md. 21228 of νi Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 1/elers Cengostik disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any beeing to find detections. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) P.O. ate has been signed by the a page 2 should be detached 1 ☐ Yes 2 🛂 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. 2 Uprticulour 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Ce 3318/00 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 HOther (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ို 27. Manner of Death 1 Matural 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) /and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2007 30. Name and address of person whe eted cause of death (Item 23a) (Type, Print)

State Registrar Gen

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** eVI 520M nario 8 7 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Battivia (e If Under 1 Year | If Under 24 Hrs. Days | Hours | Min. Med. Ctr land N/A 5. Social Security Number 8. Date of Birth (Month, Day, Year 01/22/1952 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 ☐ F 215-48-8489 55 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" --- any injury or other traumatic event. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD HOWARD ELLICOTT CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4513 ALPINE ROSE BEND 21042 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 No WHITE Specify: <u>م</u> Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES INDUSTRIAL SUPPLIES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NORMAN LEVIN RHODA POWELL ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ILENE LEVIN / WIFE 4513 ALPINE ROSE BEND - ELLICOTT CITY, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) COLUMBIA MEMORIAL PARK 08/19/2007 COLUMBIA, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee wer 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Fourniers Gangrene disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Heart gronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Diabetes Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certificat completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1. Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D51654

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** HONCE August LEVY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinar N/A Hospital 61 Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 07/04/1916 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🔽 F Hours Min. 213-03-4720 91 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show adleal Examiner must be notified at MD BALTIMORE BALTIMORE 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8207 PARK HEIGHTS AVENUE 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or leading or other trainments. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No WHITE Specify: þ Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER STORE FIXTURES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **STRAUSS** LOUIS ELLA **UNOBTAINABLE** P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERMAN LEVY / SON <u>513 CALDERA COURT - WESTMINSTER, MD 21158</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH EL MEMORIAL PARK 08/17/2007 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Ineymonia 5 days. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner My orardial Infaration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner for use as the burial-tran attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) 9☐Unknown ed i y the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sign Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Hypertension. 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Dementid Advanced 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P leral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital within 24 hours a

Maryland 21215-0036

Baltimore,

State Registrar 29b. Signature and title of certifier

31. Date filed (Month.

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32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 14, 2007 3:15 P Catherine Lynn LaVoie August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10003 Crane Lane Baltimore Baltimore 8. Date of Birth (Month, Day, Year)
Oct. 23, 1939 Massachusetts If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F Director 013-30-2144 67 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10003 Crane Lane Funeral 21220 U. S. A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: 3 X Widowed 4 ☐ Divorced White Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) the 4 Teacher School 1 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item ZZ Is marked oth any injury or other traumatic event sonce. 18. Mother's Name (First, Middle, Maiden Surname) Be John O'Loughlin Laura Morel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew LaVoie (Son) 10003 Crane Lane, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory of other place) Massachusetts National Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/21/2007 Bourne, Massachusetts 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Uterine MULL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter throughlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. physician s the burial Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) signed by the aid be detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed?

1 Yes 2 No 25. Was case referred to medica examiner? B 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient P 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: I or Attending F after death. 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: / 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifie

31. Date filed (Month,

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29d. Date signed (Month, Day, Year)

BALTIMORE

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and manner stated.

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Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Donna Maria McCo	1- For State	te of Maryland / Depar <i>Cert</i>	tment of Health a	nd Mental Hygiene	Reg. No. 2007 2554
Physician/	1. Decedent's Name (First, Middle,	Last)		2. Date o	f Death 3. Time of Death
Medical Examine	Donna Maria Mo				st 15, 2007 Year 1008 hrs
	4a. Facility Name (if not institution, 610 Cooks lane Apt. 10	,	4b. City, Town, o Baltimore	or Location of Death	4c. County of Death
Funeral	5. Social Security Number un 1-6	. Sex 7. Age (In yrs. las			of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
Director	206-36-6516	1 M 2 X F 59	Yrs. Months Da	ys Hours Min. May	6, 1948 Maryland
,	Usual Residence of Decedent 10a. State 10b. County	Idoc City T	own or Location		And Inside City Limits
ow any	1	Toc. City, 1			10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show d at once, ector	MD 10e. Street and Number		Baltimore 10f. Zip Code		10g. Citizen of What Country?
the land	610 Cooks Lane	#102	l '	1229	USA
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene Important: If I tem 27 is marked other than "natural", or items 23 in a marked other than "natural", or items 21 injury or other traumatic event, the Medical Examiner must be an To Be Completed by Funeral	11. Marital Status 1 X Never Married 2 Mar	ied 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 X No		lispanic Origin? (Specify Yes an, Mexican, Puerto Rican, etc	
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213 tould b d Men d Men s marl tic eve	19a. Informant's Name/Relationshi		19b. Mailing Address (Stre		e Number, City or Town, State, Zip Code)
MD d 2 sho lth and n 27 is numat	Rakia McCoy/dau	ghter	610 Cooks La	ne #610 Baltin	nore, MD 21229
re, s 1 and f Heal if item er tra	20a. Method of Disposition 1 Burial 2 X Cremation		ace of Disposition (Name of c ematory or other place)	emetery, Date	20c. Location - City or Town, State
Baltimore, permit. Pages 1 an Department of He Important: If He Injury or other tr	4 Donation 5 X Ott)er Spe	Tremovar from State	enmount	8-24-07	Baltimore, Md.
Salti ermit. epartr nport ijury	21. Signature of Euneral Services	censeede, Director	22 Name ar Ang	FERRING Greene 5	uneral Services
	/smill	(Delle	Baltimore	MD 2 21201	5151 Balto. Nat'l Pike
Physician /Medical	failure. List only one cause of				Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Hypertensive Atheroscle Due to (or as a consequence of):		isease	Death
	Sequentially list conditions,	b			
ted nsit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of):			
	events resulting in death) Last	Due to (or as a consequence of):			
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Box 68760, he death certificate be the attending physic hed for use as the burn Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregna	ancy 2 Fetal death 3	Ectopic pregnancy	23d. Date of delivery Month Day Year
ox 6 auth cerraterdia attendia sicia	past 12 months?	4 Pregnant at time of deal			23,
D. Bo the dea by the a tched fo	1 Yes 2 No 9 V Unkn	a Cuknown			
ords, P.O. w requires that th s been signed by should be detach	Part II. Other significant conditio	ns contributing to death but not res	ulting in the underlying cause	given in Part I. 23e.	Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown
duires quires uld be ted				1 242	Was an 24b. Were autopsy findings available
COTC law re has be 2 sho					prior to completion of cause of death?
tal Records, cian: The law require certificate has been si ector, page 2 should b Be Completed					Yes 2 No 1 Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the fumeral director, page 2 should bertification: To Be Completed	25. Was case referred to medical examiner?	Hospital:		Other: Nursing Home	
of Vit Physic For this eral din	1 ✓ Yes 2 No 27. Manner of Death	i inpatient 2	R/Outpatient 3 DOA 28b. Time of Injury 28c. Inj	To receive receive	5 Residence 6 Other: Scene
ion of vitending Phyleath. tor: After the funeral ation: Ta	1 Natural 5 Pendin	(Month, Day, Year)		Yes 2 No	sisonon injury december
IVISIOI or Attenu after death Director: I in by the	2 Accident Investig	28e Place of Injury At hon	ne, farm, street, factory, office		tion (Street and Number or Rural Route Number, City
Division o spital or Attending nours after death. neral Director: After filled in by the fune Certification:	3 Suicide 6 Could determ	not be	•		wn, State)
	29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge			cause(s) and manner as stated. date and place, and due to the cause(s)
To the Ho within 24 To the Fu Completel		and manner stated.			
_	29b. Signature and title of certifier	0/01/00		Ise number	29d. Date signed (Month, Day, Year)
	Mudl	Malla		.M.E.	August 15, 2007
(4)		ho completed cause of death (Item 2 stant Medical Examiner 1	^{3a)} 11 Penn Street, Baltin	nore, MD 21201	
State		32 Registrar's Signature		,	
Registrar	A s a a	2007 Jan 1	Coart !		
DHMH 17 Rev 1/2001		1	ORIGINAL		

State of Maryland / Department of Health and Mental Hygiene 26644 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** August 15, 2007 3:47 PM M Michael Manns /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 58 Sept 12, 1948 Director 216-48-2628 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1√Yes 2 No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 5715 Willowton Avenue 21239 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ Specify: black 3 ☐ Widowed 4 No Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 27 is marked other
any injury or other traumer. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Manns Margaret Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bayala Kinard/sister 5715 Willowton Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4□Donation 5♥Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Euneral Strice Licensee Ronald S. Wade, Director Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a MULTIPLE MYELOMA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 TUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 2**X** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After t completely filled in by the funera Certification: Division 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 43725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)-32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene - State Registrar Amend 17,18. perFD, g870, 8/30/07 TCertificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** August 13, 2007 9:50AM Victoria Montalvo /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore FutureCare Cherrywood Reisterstown Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🛛 F Yrs 90 March 23,1917 Puerto Rico 050-05-9287 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State 10b. County item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Mudical Examinar must be notified at 1 Yes 2 No Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21136 USA 306 Cantata Court, Apt. B7 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status e filed within 72 hours after un Hygiene.

Hygiene.

other then "natural", or Itel 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1⊠Yes 2□No Specify: Puerto Rican White Specify: Saltimore, Maryland 21215-0036 ģ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clothing Seamstress 12 Mother's Name (First, Middle, Maiden Sumame)
Valericanna Garica permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked otherny injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be **Unknown Valerie** Prudence Aloyo Wenceslao Aloyo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12332 Diploma Drive, Reisterstown, MD 21136 Judith Geppi Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/18/07 Reisterstown, MD 4 Donation 5 Other (Specify) Saints' Cemetery 21. Signature of Euneral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Lus Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroschevotic cerebral Vascular **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed ettending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No 2 No certificate 1 Yes : After this certifical funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 25 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. after death | Director: / d in by the f 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 15, 2007 037573 d cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete MD Mam MD Zbell 25 Et 31. Date filed (Month, Day, Year)-32. Abdistrar's Signature State Registrar AUG 2 0

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- Stete Registrar Amend 29c, perDVR, g870, 8/18/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 8 BAby Mazariegos 0450 M /Medical 4a. Facility Name (If not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death EASton EASTON Memorial 1 A-1607 | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 MF NONE Md. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Itams 23a or 28a-f show 10d. Inside City Limits the Medical Examinary wat be notified at GrASONVille by Funeral Director Queen Cane 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 ation 21638 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 Mexican 1 ☐ Ves 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: "natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any injury or other traumatic avant, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) 0 none none 17. Father's Name (First, Middle, Last) Be unk 18. Mother's Name (First, Middle, Maiden Sumame) MazaRi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mother Station Lane Grasonville Md 106 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature Funeral Style Licensee

22. Name and Address of Facility
State Anatomy Board 655 W. B

Baltimore, MD 21201

23a. Parli. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician pretern premance /Medical Due to (* as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): vision of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown memanu certificate has been Limutted 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? prenatal 2□ No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? within 24 hours after deam.
To the Funaral Director: After t 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) thairan C H61208 DOIMS who completed cause of death (Item 23a) (Type, Print) Shawn win De, M.S.

(ear)

1 2 2007

32. Gistrar's Signatura

1 2 2007

State Registrar 31. Date filed (Month, Day, Year) AUG 1

07-06318 Frederick Moore

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	1- For State	Certificate of Death	Reg. No. 2 Date of Death 3. Time of Death
Physician/ edical Examiner		e moore	Month Day Year 2118 hrs August 15, 2007
	4a. Facility Name (if not institution, give street University Hospital	the Other Training and appring	~/4
Funeral Director	5. Social Security Number 6. Sex 15-96-1478 1 M	Months Days Ho	nder 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Min. 04-07-1980 Foreign Country)
/ any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location Batternal	10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f show any tified at once. Director	10e. Street and Number	fayette are 2121	10g. Citizen of What Country?
after death with the Maryland hir, or items 23a or 28a-f shor iner must be notified at once. by Funeral Director		Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specify Yes of No- 14. Race - American Indian, Black,
after after	45 December 15 Education (Specify only bi	ates:	cify: Specify: live kind of work done 16b. Kind of Business/Industry
e, MD 21215-0036 1 and 2 should be filed within 72 hours afte Health and Mental Hygiene. Titem 27 is marked other than "natural", I traumatic event, the Medical Examiner Trans Completed by	Elementary/Secondary (0-12)	College (1-4 or 5+) NA Labor Labor	er Fraustry
215-0036 be filed within 77 ratal Hygiene. rked other than ent, the Medical Be Comple	CAO dONICK W	MU SR. A	other's Name (First, Middle, Maiden Surname) andra Mit dell
MD 21215 d 2 should be file lth and Mental H n 27 is marked t aumatic event, I	19a. Informant's Name/Relationship (Type, Ve) ma more- G	rand mother 608 W Luso	Number or Rural Route Number, City or Town, State, Zip Code) Here Bullo and 2 (21) Date 20c. Location - City or Town, State
5 8 2 = 4 l	20a. Method of Disposition 1 V Burial 2 Cremation 3	20b. Place of Disposition (Name of cemeter crematory or other place) The Company of the place o	Secretary or respiratory arrest, shock or heart Approximate Interval
Baltimore, permit. Pages I ar Department of Hee Important: If ite	21 Signature of Funeral Service Licensee	22. Name and Address of F	vallace f. Service Butto and 2125
Physician	23a. Part I. Enter the disease, or complicat failure. List only one cause on each I	ions that caused the death. Do not enter the mode or dying, such	'as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
xaminer	or condition resulting in death) Due	to (or as a consequence of):	
	Course. Enter Underlying Cause (Disease or injury that initiated	to (or as a consequence of): to (or as a consequence of):	TO DESCRIPT TO THE PARTY OF THE
be exiction urrial	S S S S S S S S S S S S S S S S S S S	MENDED	23d. Date of delivery
Box 68760, s death certificate b the attending physic of for use as the bu	past 12 months?	Pregnant at time of death 5 Other (Specify)	ctopic pregnancy Month Day Year
Division of Vital Records, P.O. Box 687 To the Hospitat or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.		Unknown ntributing to death but not resulting in the underlying cause given	n in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown
Division of Vital Records, P.O. nat or Attending Physician: The law requires that the rs after death. In Director: After this certificate has been signed by the funeral director, page 2 should be detachled in by the funeral director, page 2 should be detach.	Completed by		24a. Was an autopsy autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
ecc he lav ate ha			1 Yes 2 No 1 Yes 2 No
II. T	25. Was case referred to medical	Tour	Death (Check only one)
Vital Rec	examiner? 1 Vyes 2 No	i patient 2 Erooupatient 6 50%	er4 Nursing Home 5 Residence 6 Other: t Work? 28d. Describe how injury occurred
on of anding Phath.	27. Manner of Death 1 Natural 5 Pending		2 ✓ No Subject shot
Division and or Atternation and Director led in by t	27. Mainter of Death 1 Natural 5 Pending 1 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office build (Specify) Local Street	700 blk. Brune Street , Baltimore , MD
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	(Check only one) 2 Medical Examiner: C	: To the best of my knowledge, death occurred at the time, date n the basis of examination and/or investigation, in my opinion, do not manner stated.	eath occurred at the time, date and proof, and doo to the date of
To the within To the comple	29b. Signature and title of pertifier	nd manner stated. 29c. License n	umber 29d. Date signed (Month, Day, Year)
	30. Name and address of person who co	O.C.M.	E. August 16, 2007
31	Melissa Brassell, MD Ass	istant Medical Examiner 111 Penn Street, Bal	timore, MD 21201
Sta	ate 31. Date filed (Month, Day, Year)	32. Redistrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 17, 2007 12:45 pm Jacqueline Nickel August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Manor Care Health Services Rossville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 □XF Months Days Hours Min. Director July 28, 1942 Maryland 212-44-6386 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant, If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 721 Rockaway Beach Avenue 21221 S. A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 XWidowed 4 ☐ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Journalist Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 John Moore Marian Nickel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. Huffines (Son) 29 Joggins Court Middle River, Maryland 21220 John 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 8/18 2607 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6 cy forna **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician a Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1□ Yes 1 ☐ Yes 2 □ No 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F 1 □Natural Injury 5 Pending nours after death, neral Director; Af filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Hospital 29a. Certifier TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ardon

7842

32. Registrar's Signature

balcwood

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Amend #26, per Verb. 0870, 8/20/07 TT Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **IRENE** NATHAN **AUGUST** 2007 7:46 PM 16 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1801 E. JEFFERSON STREET ROCKVILLE MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign POLAND 1 ☐ M 2 👿 F 215-12-8612 85 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No MD MONTGOMERY ROCKVILLE 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 1801 E. JEFFERSON STREET 20850 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No WHITE Specify Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE CITY Elementary/Secondary (0-12) College (1-4or 5+) **ADMINISTRATOR** GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ISAAC BERGER MOLLY GOLDFARB 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRVIN NATHAN / SON <u>4924 TILDEN STREET N.W. - WASHINGTON, DC 20016</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) SHAAREI TFILOH CONG. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/19/2007 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE RESPIRATORY FAILURE Due to (or as a consequence of) METASTATIC BRONCHOGENIC CARINOMA Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a, Was an autopsy performed? Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 3□ DOA

Physician /Medical Examiner

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

2 should be filed within 72 hours after on and Mental Hygiene.

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Baltimore, Maryland 21215-0036

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Funeral

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Physician/Medical

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Certification:

Medical

27. Manner of Death

1 XNatural

2 Accident

3 ☐ Suicide

29a. Certifier

29b. Signa

4 Homicide

(Check only one)

31. Date filed (Month, Day, Year)

AUG 2

To the Hospital or within 24 hours af To the Funeral D completely

State Registra

ddress of person who completed cause of death (Item 23a) (Type, Pint) LERNER 1120 STEVEN 32. Régistrar's Signature

5 Pending investigation

6 Could not be determined

19th STREET N.W

28a. Date of Injury (Month, Day Year)

and manner stated.

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DC MD 11924 08/17/2007

28d. Describe how injury occurred

-WASHINGTON, DC 20036

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Marylan per Inf., g8	nd / Depa 1,09/ 0	artment 6/07dl	of Health a of Death	and M	ental Hygi	ene g. No.	7	266	50
	Dhysis		Decedent's Name (First, Middle, Last)					2. Date of Death Month		'oar	3. Time of	Death
	Physici /Medi		Brooke G. O'Kane Sr					August	$12^{\circ}, 200^{\circ}$	'ear 7	10:00) AM∕
2	Examir	ner	4a. Facility Name (If not institution, give street and number)			wn, or Location			4c. County of			
			6504 Baltimore Avenue			ersity P			Prince			
b	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs.	Yrs.	If Under 1 Months	Year If Under Days Hours	Min.	8. Date of Birth (Month, Day,)ct 12,	Year) 1935 Wa	Coun	lace (State or try) ng t on	
	land ow			ty, Town or Lo	cation					11	0d. Inside Cit	y Limits
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21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mentai Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic event, the Medical Experient must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Year or Dates: 15. Was Decedent Ever in U Armed Forces?	1	Vas Deceder f Yes, specify I ☐ Yes 2∑	nt of Hispanic Ori Cuban, Mexican No Specify:	i, Puerto F	cify Yes or No- lican, etc.)	14. Race - Black, Specify:	White,	etc.	
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≥	and 2 sho ealth and n 27 is m		Estelle O'Kane/spouse					Jniversi				
Baltimore,	Pages 1 and 2 nent of Health ant: if Item 27 i		20a. Method of Disposition 20b. I	Place of Dispo	sition (Name	of			Oc. Location - Ci			32
Balti	permit. Pages Depertment of Important: If I any injury or once.		21. So neture of Funeral Serice Licensee Point S. Waye, Director			atomy above		655 W. I	Baltimor	e St	treet	
			23a. Part. Enter the disease, or complications that caused the deal shock or heart failure. List only one cause on each line.					respiratory arres	st,		Approximate Interval Betw	
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	/Medical		resulting in death) Due to (or as a consequence)	uence of):	1000			ma	/ 4		1/	
	Examiner		Sequentially list conditions	fect	B	lan T	rou	ma	MVA	1	7/09	eun
	si ad	ine	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):								
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87	cate	dicai	d		_							
.O. Box (that the death certific led by the attending p detached for use as	Physician/Me	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of december 2 □ Pregnant at	Ideath 3□	Ectopic preg Other (speci				23d. Date of Month		-	ear
<u>α</u>	that led by deta	F.	Part II. Other significant conditions contributing to death but not res	ulting in the un	derlying caus	se given in Part I.		23e. Did toba	cco use contribu	ite to the	e cause of de	ath?
ords	w requires that the been signed by th should be detache	ted by						1 ☐ Yes	2 □ No 3[□ Proba	ably 4 Dur	nknown
	The law ete has b page 2 si	Completed						24a. Was an autopsy performe	ad;? dea	re autop r to com th? Yes	sy findings and pletion of call	vailable use of
₹	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:			04-		Check only one				
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	To the within 2 To the complet	ž	29b. Signature and little of certifier			cense number	(4.5	290	I. Date signed (A	Nonth, D	Day, Year)	
)			John Men Man			1) 210	138		ttagu	A1	4,200	27
			30. Name and address of person who completed cause of death (Item MIC (1992)	1 116	Print) FEW	E HI	GHU	IAy Aa	INAROL	5 W	10214	01
	Sta Registra		31. Date filed (Month, Day, Year) 32. Alegistrar's Signa	ture A	arti							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WALTER THOMAS OBRIEN 11:15 P M August 11, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New York 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Days Hours 1 XM 2 ☐ F 85 Yrs 078-18-2293 Jan. 20, 1922 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 X Yes 2 No Loudoun Leesburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Memorial Drive NW 20176 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 A Married White 1 ☐ Yes 2 ₺ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Special Agent FBT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter T. O'Brien Anna Maxcy 19a. Informant's Name/Relationship (Type. Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40879 Meadow Vista Place Lovettsville, VA 20180 Thomas F. O'Brien - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State John's Cemetery 8-16-2007 4 ☐ Donation 5 ☐ Other (Specify) Leesburg, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Colonial Funeral Home 201 Edwards Ferry Road NE Leesburg, VA 20176 2. a. P rrt1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final decase or ondition resulting in death) BEPSIS WK Due to (or as a consequence of): FUNGEMIA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) a∏lJnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEMENTIA, PARKINSONSUS. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

Physician /Medical **Examiner**

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Division or Vital

permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, the

Physician

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within 72 hours after

Maryland 21215-0036

Baltimore,

burial-transit

Examine Completed 25. Was case referred to medical Be 1 ☐ Yes

27. Manne

29a. Certifier

Medical

3 ☐ Suicide

4 ☐ Homicide

Physician/Medical þ

physician nse ed by the a signed to certificate has director Certification: To this funeral After filled in by the

To the Hospital or Attending within 24 hours after death.
To the Funeral Director; After

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

WIVER TOUCOSIS

24a. Was an autopsy 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No

examiner? 1 ☐ Yes 2 ☐ ✔	6	Но	spital: 1 🗷
Manner of Death			28a. Date
1 Natural	5 Pending		(Mo
2 Accident	investigation	1	

Inpatient 2 ER/Outpatient 3 DOA e of Injury onth, Day Year) 6 ☐ Could not be determined . Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

and manner stated 29c. License number MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 65C THOMAS JOHNSON OR. FREDERICE 11762

DONE WOON MO 31. Date filed (Month, Day,

32. Registrar's Signature

State Registrar

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/Medic Examin		4a. Facility Name (If not institution, s	give street and number)				Location of Death			. County of De		2020
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with the a or 28a	Direc	10e. Street and Number				10f. Zip Code				izen of What	Country	?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	4216 Wolf Hill D 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces?			21074 Was Decedent of H If Yes, specify Cuba 1 □ Yes 2X No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	U.S	14. Race - Ar Black, Wi		
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und 2 shou alth and M 27 is ma er trauma	a	19a. Informant's Name/Relationship Kim M. Sevik	(Type. Print) Daughter			ng Address (Street Wolf Hill						de)
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permit. Departi Import any Inj		21. Signature of Funeral Service Li	582.		E	2. Name and Addre	RAL HOME	Reist	erst	sterstoown, MI		
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 🗆 Fetal	death 3	Ectopic pregnancy	,			23d. Date of a	lelivery Da	y Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear PIEHIER GLORIA 5:15 AUGUST 14 7.007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CITY JOHNS HOPKINS BHYVIEW MEDICAL CENTER BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F 5/6/1936 213 34 4099 Maryĺand 71 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8103 Beachwood Rd Apt A 21222 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Tyes 2 No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 ☐ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Accountant Car Dealership 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Allen Siemon Mary Elizabeth Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7933 Royal Mint Place Cynthia E. Teeter/daughter Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 8/15/07 Baltimore, MD 21. Signature of Funeral Vivice Licensee 22. Name and Address of FacilityGJ Gonce Funeral Home, 169 Riviera Dr. Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PSIS day 5 elivery Year Day to the cause of death? robably 4 Unknown autopsy findings available completion of cause of

2007

29d. Date signed (Month, Day, Year)

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Physician /Medical Examiner

Important: If its any injury or o

Physician

/Medical

Examiner

Director

Funeral

Completed by

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MD

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglenc. and it is filem 27 is marked other than "hatural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician/Medical Examiner burial-trar ed by t detach s been signed be should be deta Completed by page 2 Certification: To Be funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

this

After

To the Hospital

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Bewel Ova Stamos Due to (or as a consequence of): c Due to (or as a consequence of): d	s leak		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		c pregnancy (specify)		23d. Date of delivery Month Day Yea
Part II. Other significant conditions	contributing to death but not resulting in the underlyin	ng cause given in Part I.		use contribute to the cause of deat
			24a. Was an autopsy performed?	24b. Were autopsy findings ava prior to completion of cause death? 1 □ Yes 2 ☑ No
25. Was case referred to medical examiner?			ath (Check only one)	
1 ☐ Yes 2 No		DOA Other: 4 Nursing H	lome 5 🗆 Residence	6 □Other (Specify)
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred
3 ☐ Suicide 6 ☐ Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		nd Number or Rural Route Number e)
29a. Certifier 1 Certifying P	hysician: To the best of my knowledge, death occur miner: On the basis of examination and/or investiga	red at the time, date and place tion, in my opinion, death occu	t a, and due to the cause(s urred at the time, date an	s) and manner as stated, ad place, and due to the cause(s)

and manner stated.

4940

32 Registrar's Signature

M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

n State Registrar 29b. Signature and title of certifier

Simplini

CHRISTUPHEN

31. Date filed (Month

EASTERN

29c. License number

AVENUE

Q4122

BALTMORE

		1- State of Maryland / Department of Health an Certificate of Death	Reg. No. 2	6651
Physic /Medi		1. Decedent's Name (First, Middle, Last) Helen Peters	Month Day Year	ime of Death
Examii Funeral			teath 4c. County of Death 1e Baltimore Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace Country)	(State or Foreign
Director		217-38-4563		side City Limits
the Maryl 28a-f sho otified al	ector	MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code		□Yes 2□xNo
s 23a or nust be r	Funeral Director	1314 Hickory Springs Circle 21228	USA	11-
be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	₽	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P 1 □ Yes 2 ☑ No Specify:	? (Specify Yes or No- lucrio Rican, etc.) 14. Race - American Ind Black, White, etc. Specify: Whit	·
filed within 72 ho Hygiene. other than "natul ent, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) homemaker	working 16b. Kind of Business/Industry own home	
e da a	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's	Name (First, Middle, Maiden Surname) a Contogeorge	
d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Type. Print) Joy Kay Deuber, daughter 19b. Mailing Address (Street and Number of 1314 Hickory Spring)	or Rural Route Number, City or Town, State, Zip Code s Circle, Catonsville, M	id. 2122
S = = .		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Greek Orthodox Cem. 8/	Date 20c. Location - City or Town, S 21/2007 Windsor Mill, M	ld.
Definit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility of Catonsville, willc, Md. 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.		
Chysician and physician and street physician and street physician and street physician are the burial-fransit as the burial-fransit	edical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Last Cause (Disease or injury that initiated events resulting in death) Last Last Cause (Disease or injury that initiated events resulting in death) Last Last Cause (Disease or injury that initiated events resulting in death) Last	Istase	val Between et and Death
D 0	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown	23d. Date of delivery Month Day	Year
te has been signed by the attending age 2 should be detached for use	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cau	
	Completed		24a. Was an autopsy fination autopsy performed? 1 Yes 2 No 1 Yes 2 □	on of cause of
within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	tion: To Be	examiner?	Death (Check only one) ng Home 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred	
within 24 hours after death To the Funeral Director: , completely filled in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Rou City or Town, State)	te Number,
in 24 hours a	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and process of examination and/or investigation, in my opinion, death and manner stated.	occurred at the time, date and place, and due to the	
Vithin To the comple	M	29b. Signature and title of certifier Physics 29c. License number D 3 8 6 6 2	29d. Date signed (<i>Month, Day,</i>	Year)
γ		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Walsh - 4660 Walkens Avenue Back more 31. Date filed (Month, Day, Year) AUG 2 0 2007 32. Registrar's Signature	MD 21229	
Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 0 2007 32. Registrar's Signature		

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Amend Item 26 per verb., g870,08/20/07dhb Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 0340 /Medical 4a Facility Name (If not institution, give stre 4b. City, Town, or Location of Deeth 4c. County of Death Examiner ursing la Baltimore 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 05 Months Days 1 M 20 F Hours Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28e-f show the Madical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director 10e Street and Number 10f. Zip Cod 10g. Citizen of What Country? Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiane. Important: If them 27 is marked other than "natural" — eny Injury or other treumatic aven. Black, White, etc. Yes 212 No 1 Never Married 2 Married 1 ☐ Yes 2 No à Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U. S. Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillie Porter ပ Willie Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Beverly Salvant/sister 1 Stayman Court #E Catonsville, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serie Ronald S. Wade. 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street D1 rector Baltimore, MD 21201 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearl failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Atherosclenatic Cardiorascular Disease Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner or Attending Physicien: The law raquiras that the death certificate ba executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of To the Hospital or Attending Physicien: The law raquiras that the des within 24 hours after death.

To the Funerel Director: Aftar this cardificate has been signed by the air completely filled in by tha funaral director, paga 2 should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably All Unknown 1 Yes 2 No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To 2[Hospital: Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Manner of Death 28c. fnjury at Work? 28d. Describe how injury occurred 1 Natural 2 ccident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type Print) 12000 CE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 17, 2007 5:30 am^M Mary Marguerite August Schultz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 523 Sugar Hill Road Harford 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🛣 F Hours 79 220 22 4715 Director Oct.10,1927 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. In the Mental", or items 23a or 28a-f show int. If item 27 is marked other than "natural", or items 23a or 28a-f show Int. or other traumatic event, the Medical Examiner must be notified at Int or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits Harford 1 ☐ Yes 2 No Director Maryland Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 523 Sugar Hill Road 21085 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alonzo King Nora G. Lipps ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Ruth (Daughter) 523 Sugar Hill Rd. Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 8/21/2007 Department of Important: If any injury or once. Elkridge, Maryland 4 Donation 5 Dother (Specify) Funeral Service Licen 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Muccocdial disease or condition resulting in death) /Medical Due to (s a consequence of) Examiner ola nana Sequentially list conditions. Physician/Medical Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760. use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown ō Month Day Year 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate 2 X No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐Pending investigation 2 □ No 1 Tyes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division or Vital Records, or Attending Physiclan: ours after death.

neral Director: A
filled in by the fu To the Hospital within 24 hours a

Registrar

State

Medical

29a. Certifier

(Check only one)

31. Date filed (Month,

29b. Signature and tine of certifier

Muneses Day, Year)

AUG 2

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1845

32. Redistrar's Signature

ess of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DAGWOOD

29c. License number

053462

Road Glen Purnie

29d. Date signed (Month, Day, Year)

10015 am

07-06345 Kathleen Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	J	I-For State Registrar		Certific	ate of De	ath		Re	eg. No. 200	7 2665
Physicia Medical Examii	111/4	1. Decedent's Name (First, Middle,La Kathleen C. S			1.7			2. Date of Dea Month August 16	Day Year	3. Time of Death 1150 hrs
the sail		4a. Facility Name (if not institution, gi			4b. Ci	ty, Town, or L	ocation of D		4c. County of Deat	
		1203 Glyndon Avenue	T=a'			ltimore	1	To a	n/	
Funeral Director	- 1	5. Social Security Number 6. 8 213-64-3443	M 2 X F 52	ı yrs. last birt	Me	Inder 1 Year onths Days	If Under 24 Hours	Min	Forei	rthplace (State or gn ountry) MD
	L	Usual Residence of Decedent	M ZAF JZ		Yrs.		ll	1/20,	/1955 0	ountry)
v any	Ī	10a. State 10b. County	100	c. City, Town				7		10d. Inside City Limits
/land -f show once.	ģ	MD n/a		Ва	altimo			т.		1 X Yes 2 No
e Mary or 28a	Director	10e. Street and Number 1203 Glyndon	Δινοημο		101	Zip Code 2122	2	1	0g. Citizen of What Cou	-
with th	neral L	11. Marital Status	12. Was Decedent Eve	er in U.S.		edent of Hisp	anic Origin?	(Specify Yes or No	USA - 14. Race - Ame	rican Indian, Black,
death or iten	Fune	1 X Never Married 2 Marrie	d Armed Forces?	No	If Yes, sp	ecify Cuban,	Mexican, Pu	uerto Rican, etc.)	White, etc.	7.71.
s after rral",	۵	3 Widowed 4 Divorce 15. Decedent's Education (Specify	d If Yes, Give Year or Dates:	tod) Isa		2 X No		d of work done	Specify:	White
2 hour	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)		during most of				16b. Kind of Business	rindustry
5-0036 ed within 7. tygiene. other than	Completed	9	0		non	е			none	
15-0 filed w I Hygi ed othe	ပ္မ	17. Father's Nama (First, Middle, Las James C. Smit	•			18		lame (First, Middle, I		
MD 21215-0036 42 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medical	To Be	19a. Informant's Name/Relationship		19	b. Mailing Add	ress (Street		S F. Sl	eeman nber, City or Town, Stat	e, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she njury or other traumatic event, the Medical Examiner must be notified at once		Charlene Smit	h / Sister] 1	203 G	lyndo	n Ave	enue, Ba	ltimore,	MD 21223
Baltimore, Moemit. Pages I and 2 Department of Health Important: If item 2 njury or other traun		20a. Method of DispositionBurial 2 XCremation 3	Removal from State	cremat	of Disposition tory or other pl	ace)		Date	20c. Location - City o	
Baltimore, permit. Pages I ar Department of Het mportant: If ite		4 Donation 5 Other Specif	y:	Bayv					Baltimor	
Bal permit Depar Impo		27. Signature of Funeral Service Lice	nsee .		22. Name	and Address o	of Facility E	Hubbard I	Funeral H Baltimore	ome, Inc. , MD 21229
Physician	1	23a. Part I. Enter the disease, or comfailure. List only one cause on		death. Do no						Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (Final disease	Atherosclerotic Ca		ılar Disease	e				Death
		or condition resulting in death)	Due to (or as a conseque	ence of):						
	je l	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause	Due to (or as a conseque	ence of):						
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recuted . transit	al E		l							
760, Trate be executed the burial - trans	Medical	UNPENDED IF FEMALE:	AMENDED	of avancas:					Local Date of delive	
		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2	Fetal de	ath 3	Ectopic pr	egnancy	23d. Date of delive Month	Day Year
Box 687 death certificates at the attending	Physician	1 Yes 2 No 9 V Unknow	Pregnant at time	e of death _{	5 Other (Specify)				
O. E at the d I by the tached		Part II. Other significant conditions		it not resultin	g in the underl	ying cause giv	ven in Part I	. 23e. Did to	obacco use contribute to	the cause of death?
S, P.(nires than signed d be det	d by							1Yes	s 2 No 3 Pro	obably 4 🗸 Unknown
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Vital ysician: his certil director	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 FR/O	utpatient 3		thor:	neck only one)	Residence 6 ✔ Other	or: Scene
Division of Vital Records, P.O tal or Attending Physician: The law requires that t rs after death. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be deace.	2	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b.	Time of Injury	28c. Injury			how injury occurred	br. ocone
ion Itendir Heath. Tor: A	aţio	Natural 5 Pending Accident Investiga				1 Ye	es 2 No			
Division of or Attenors after death Directors of in by the	Certification:	3 Suicide 6 Could no	t be 28e. Place of Injury	- At home, fa	arm, street, fac	tory, office bu	ilding, etc.	28f. Location (or Town, S		tural Route Number, City
Di e Hospital o 24 hours a e Funeral I letely filled	2	29a. Certifier	cian: To the best of my kn	nowledge de	ath occurred a	t the time date	e and place	and due to the caus	se(s) and manner as sta	ited
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be deached for use as	ledical		er: On the basis of examination and manner stated.							
F 3 F 3	š	29b. Signature and title of certifier				29c. License			29d. Date signad (M	
			J. mos			O.C.N	1.E.		August 17, 200	7
١		30. Name and address of person who Ling Li, MD Assistant I	•		n Street, B	altimore, M	1D 21201			
St	ate		32. Registrar's S	Signature	A al					
Regist	rar		1001 paracres	11.	STEAN.	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 4:29 P.M 2007 August 15, Billie Jan Snyder /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Manchester 5117 Black Rock Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 M 20XF 66 1941 New Jersey 157-28-8420 Apr. 12, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show rai", or items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yes XX No Directo Maryland Carroll Manchester 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number America 14. Race - Am 5117 Black Rock Road Funeral . Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after of Hygiene. other than "natural", or Iter 1 ☐ Yes 2**X**Xlo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXVo Specify Specify: Saltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Long View Nursing Home Head Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental n and Mental Emily Lasbury Arthur Powell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i Manchester, Maryland 21102 5117 Black Rock Road; Bruce A. Snyder (Husband) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or ot Aug. 18, 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation (Speoily) 2007 Lineboro, Maryland Lazarus Church Cem. 22. Name and Address of Facility Eckhardt Funeral Chapel, 3296 Charmil Drive; Manc Signature of Fund & Service Lie Manchester, Maryland 21102 Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final disease or condition resulting in death) Carcer 2 MONTH Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending phy IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by d be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has le 2 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No ို 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: Atter 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: At To the Funeral Director

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

GENTERY AVE BALTIMORY MILLINEY

e of eath (Item 23a) (Type, Print) 30. Name and address of person who completed au

JHBUML 4940 MICHRIZL 2. Registrar's Signature

AUG 2 0 2007

29a. Certifier

(Check only one)

Medical

State

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 200 :08PM Mary Josephine Sampery Hugust /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** venct 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2 1 F 216-01-9869 98 Sept 23, Director 1908 MD. Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 Txt No Director MD Baltimore Catonsville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane HR 436 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examines 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No white altimore, Maryland 21215-0036 2 Specify 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) retail dept. store office clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Pappa 2 Anna Alascio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Gosselin, daughter 416 Stafford Road, Stevensville, Md. 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c, Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crestlawn Memorial 8/21/2007 Marriottsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke F.H. of Catonsville, Inc., 1630 Edmondson Ave. Catonsville, Md. 21228 21. Signature of Juneral Service Licensee demmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ttherosclerati disvascular disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate 2 To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Descriting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 30 Name and addres of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** August 6, 2007 12:23 PM Eleanor D. Vernon-Williams /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Caroline Denton Caroline Home for Hospice If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🛱 F Yrs. Aug 11, 1923 Massachusetts Director 024-18-1113 83 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28s-f ehow with Ijury or other traumatic event, the Medical Examplest must be notified at once. 1 ☐ Yes 2 ☐ No Denton Director Caroline 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21629 USA 613 5th Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) education librairian 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jessie Achord Everett A. Dunham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 513 S. Washington Street Easton, MD Doris Hall/executor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 → Other (Specify) 21. Signature of Funeral Service Licensee Ronald S, Wade State Anatomy Board 655 W. Baltimore Street Director mi 124 Baltimore, MD 21201 23a. Part i Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Obstructue Puroran Immediate Cause (Final disease or condition resulting in death) Chronic Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. tallin 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown atro been sign 24b. Were autopsy tindings available prior to completion of cause of death? 24a Was an page 2 s certificate has 1 ☐ Yes 2 ☐ No 1 Tes 2 No After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Mether (Specify) HOSpice Hospital: 1 ☐ Yes 2 ☑ No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: or Attending 1 Natural 5 Pending investigation 4 hours after death. Funeral Director; Aft ely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours aft To the Funeral DI completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 08/10 H42587 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easton mA Schilling 555 Cywood A DU 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day August 16, 2007 10:30 AM^M Calvin C. Weaver 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1₩ 2□ F Months Days Hours Maryland Apr 13, 1925 219-18-3166 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits 1 ☐ Yes 2√☐ No MDBaltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 National Drive 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 43-46 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) sheet metal 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Lillian Drimmel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Weaver/son 8 National Drive Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4∏Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Ser Ronal d vice Licensee S. Wade Director Baltimore, MD 21201

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MĎ Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic obstructive pulmonary nats Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1. Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner Box 68760, Division or Vital Records, P.O.

51918

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical

the attending physician hed for use as the burial

been signed by the should be detached

director, page 2 should

certificate

After this

completely filled in by the

Physician/Medical

Completed

Be

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Certification:

Medical

4 ☐ Homicide

(Check only one)

29b. Signature and tile of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

Baltimore, Maryland 21215-0036

To the Hospital or Attending | within 24 hours after death. To the Funeral Director: After

State Registrar

DHMH 17 Rev 1/2001

Hospice 32 Registrar's Signature

838

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richey

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

N. Entaw St Baltimore MD 2120

29d. Date signed (Month, Day, Year) August 16, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #30, perDVR, g870, 8/20/07 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 15, 2007 August Wawrzynkiewicz William . Α. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Reisterstown 3 Ewing Drive Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1⊠M 2□F April 16,1926 81 505-24-9668 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10h County 10c. City, Town or Location item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10f. Zip Code 10e Street end Number 3 Ewing Drive 21136 <u>USA</u> Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1XTYes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Baltimore, Maryland 21215-0036 Specify. Completed by White 3X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Company 12 Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia A. Stanich William A. Wawrzynkiewicz, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i 3 Ewing Drive, Reisterstown, MD 21136 Steven C. Wawrzynkiewicz Son permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/21/07 4 ☐ Donation 5 ☐ Other (Specify) Caroll Cremation Hampstead, MD 22. Name and Address of Facility 11824 Reisterstown Road 21. Signatore of Funeral Service Licensee 21136 ELINE FUNERAL HOME Reisterstown, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** TB /Medical Due to (or as a consequence of) Examiner TRA HYPERTEN Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) been signed by the sahould be detached it 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1□ Yes 2 No certificate

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

and manner stated

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Howard Goldiner, MD Reisterstown, MD

28b. Time of

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

10018662

3. Time of Death

6:00

SD

1 ☐Yes 2 No

Approximate Interval Between Onset and Death

MEDIATE

Year

Day

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 Desidence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2007

completely within 24 State Registrar

or Attending Physician:

Hospital 24 hours a

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4 hours after dec.
Therefor: After a by the further the control of the

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Certification:

25. Was case referred to medical examiner?

5 ☐ Pending investigation

6 ☐ Could not be

1 ☐ Yes 21 No

27. Manner of Death

Natural

3 ☐ Suicide

29a. Certifier

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of ce

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

PRITTAN NEUPANE

32. Registrar's Signature

MRBS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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HOSPITHU OF

AUGUST 19 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 12 30 A M TAY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore IIMONIUM If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months 1 □ M 2√F 26 /279 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No BAIMMORE naryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 UJA 4804 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 28No Specify Black Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)

Physicial /Medica Examine

Physician

/Medical

Examiner

212

Funeral Directo

pleted by

10a. State

Funeral

Director

28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified

To the Hospital or Attending Physician:

3 ☐ Suicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DR. TARIO MAHMOOD

6 Could not be determined

AUG 2 0 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Division or Vital Records, P.O, Box 68760.

5	12 the grade	Ad	MINISTIAN		140	supetal	
D D	17. Father's Name (First, Middle, Last	,			e (First, Middle, Maiden		
0	WILLIAM Cr	JMWE/1		HILD.	n Parkors		
	19a. Informant's Name/Relationship		Mailing Address (Street	and Number or Rur	al Route Number, City o	r Town, State, Zip Code	e)
W	NADOELL GARD	ordugh Husainy 4	1804 PA.	LMERA	TAlh.	non Med	2/2/3
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		Disposition (Name of , crematory or other pla		Date / 20c. Lo	cation - City or Town, S	State
	4 □ Donation 5 □ Other (Speci	ify)	war Come	Key 8/2	ATHAN - H	HINOR M	ary how
	21. Signature of Funeral Service Lice		22. Name and Addre	ess of Facility CN	AYMAN - H	DMI Feneral	Nanc
	Sur Har	ki	5240 KC1	1 TEXSTON	- ROAD L	Bothwar De	0 2/2/
	23a. Par 1. Enver the disease, or com sbrick, or heart failure. List only	nplications that caused the death. Do no	ot enter the mode of dyi	ng, such as cardiac	or respiratory arrest,	Inte	roximate rval Between
_	disease or condition	LUNG CANCER				Ons	et and Death
	resulting in death)	Due to (or as a consequence of	f):				
	Cognontially list conditions	h					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease of Krun)	Due to (or as a consequence of	F):				
	that initiated events	C					
	resulting in death) Last	Due to (or as a consequence of	f):				
		▲d					
	IF FEMALE:		-				
1	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnanc	v	2	23d. Date of delivery	V
	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4⊡Pregnant at time of death 9⊡Unknown	5 ☐ Other (specify) _			Month Day	Year
,		contributing to death but not resulting in t	the underlying series si	on in Doct I	220 Did tabassa u		
	rait ii. Other significant conditions	contributing to death but not resulting in t	the underlying cause giv	en in Part I.		se contribute to the car	
					1 Yes 2[□ No 3 □ Probably	4 K IUNKNOW
					24a. Was an autopsy	24b. Were autopsy fi prior to complet	ndings availab
					performed? 1□ Yes 2 1 No	death?	
	25. Was case referred to medical examiner?				(Check only one)		
	1 ☐ Yes 2 🗶 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	oatient 3□ DOA Oth	ler: 4 ☐ Nursing Ho	me 5 ☐ Residence €	Other (Specify)	OSPTCE
	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury 28b. Tin (Month, Day Year) Inj	me of 28c. Inju	ry at	28d. Describe how injur		~~~
	2 ☐ Accident investigatio		· ·	Yes 2 □ No			

Medical

State

Registrar

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

TIMONIUM, MD 21093

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Maryland / De State of Maryland / De C	ertificate of Death	Reg. No. 2017 216
Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year Year
/Medi	ical	Mary Belle ALSIP	4b. City, Town, or Location of Death	Hugust 9 2007 Wiss H
Exami	ner	4a. Facility Name (If not institution, give street and number) Washington County Hospital	Hagerstown	Washington
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd.	ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Birthplace (State or Fore
Director		214-09-4727	Months Days Hours Min.	(Month, Day, Year) April 14,1910 Maryland
yland now at		10a. State 10b. County 10c. City, Town or	r Location	10d. Inside City Lin
e Mar la-f sh tified	ctor	Maryland Washington	Hagerstown	1 □Yes 2 ½
th with the 23a or 28 ist be no	Funeral Director	10e. Street and Number 16331 Shinham Road	10f. Zip Code 21740	10g. Citizen of What Country? USA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yever Married 2 Married 1 Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	necify Yes or No- Pican, etc.) 14. Race - American Indian, Black, White, etc. Specify: white
72 ho "natur	Completed by	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of work te. DO NOT use retired)	16b. Kind of Business/Industry
filed within Hygiene. ther than "I	Ē	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retirea)	furniture mfg.
2 should be filed within and Mental Hygiene. is marked other than raumatic event, the M		17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)
id 2 should be file Ith and Mental Hy 27 is marked oth traumatic event	To Be	George E. Alsip	Arminta	Shrader
shou and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print) 19b. M	ailing Address (Street and Number or Ru	ral Route Number, City or Town, State, Zip Code)
1 and 2 Health a em 27 is				agerstown, Md. 21740
ormit. Pages 1 a Department of Hez mportant: If item any injury or othe		20a. Method of Disposition 2 Department 2 De	isposition (Name of crematory or other place)	Date 20c. Location - City or Town, State
permit. Pages of Department of Important: If ite any injury or of once.			.11 Cemetery 8/1:	3/07 Hagerstown, Maryland
permit. Departr Importa any inji		21. Signature of Fundral Service Licensee	Name and Address of Facility	MINNICH FUNERAL HOME
9 2 E E 9		23a. Part1. Enter the disease, or complications that caused the death. Do not		., Hagerstown, Md. 21740
Physician /Medical Examiner		shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Clevell	or respiratory arrest, Approximate Interval Between Onset and Death
ficate be executed physician and s the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C		
tificat g phy as th	edi			
The law requires that the death certifite has been signed by the attending tage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death
law req as beer 2 shou	Completed	Adult and declelon	relle hu	24a. Was an 24b. Were autopsy findings avail
Physician: The law requires t rr this certificate has been signe oral director, page 2 should be	E O			autopsy performed? prior to completion of cause death? 1
	Be C	25. Was case referred to medical	26. Place of Dea	th Check onl one
nysic lis ce direc	일	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpa	atient 3 DOA Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)
Attending Physician: r death. ector: After this certifici	tion:	27. Manner of Death 28a. Date of Injury 28b. Tim 1. Natural 5 Pending (Month, Day Year) Inju 2 Accident investigation		28d. Describe how injury occurred
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
e Hospil 124 hour e Funera letely fille	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, or the basis of examination and/or and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occurrence.	e, and due to the cause(s) and manner as stated. Irred at the time, date and place, and due to the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		fuelene 11 (Kin (M)	MC7061	7703(11 60
)H-4		30 Name and address of person who completed cause of death (Item 23a) (Ty COLUMN L 31. Date filed (Month, Day, Year) 32. Registrar's Signature	(pe, Print) (D) midual Com	en Red Magerituma

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 18 per fd aaco hlth dept 8/06/07 dlw State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MAKIA /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** uwm< DALTIMENE If Under 1 Year 6. Sex 8. Date of Birth (Month, Day, Year) Aug 31 1972 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2**X**□ F Days Hours 34 Yrs. 220-98-1375 Aug Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the M. di.cal Examiner must be notified at Maryland Anne Arundel Director 0denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1346 Burlington Dr. Funeral 21113 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th<u>Inventory Sales</u> Clerk Naval 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ronald Adams ဥ Ida Marion Ida Sharce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any Injury or other trau Ida Adams (Mother) 1346 Burlington Dr. Odenton, Md. altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Rest 4 ☐ Donation 5 ☐ Other (Specify) 8-4-07 Hanover, Md. 21. Signature of Funeral Service Licenses Mamama Repairs of Sacilisons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 S. Deese MO0883 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** O volumermine disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ESACRAL DELUBITUS William Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed Due to (or as a consequence of) Box 68760

Approximate Interval Between Onset and Death

Year

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 No

Maryland

07

N/A

USA

14. Race - American Indian. Black, White, etc.

Specify: Black

Academy

21113

11:07A

Examiner Physician/Medical 9

Completed

Be

Certification: To

Medical

been signed by the attending physician and should be detached for use as the bunal-tran certificate has page 2 After this funeral

P.O.

or Vital Records.

Physician:

or Attending Division

death.

within 24 hours after death To the Funeral Director; completely filled in by the in the past 12 months? 1 □ Yes 2 No 9 Unknown

23b. Was decedent pregnant

IF FEMALE:

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4☐Pregnant at time of death 9□Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

Day 23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CVA

determined

24a. Was an was autopsy performed?
Yes 2 \sum No Yes 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner? examiner 1 Yes 2∐ No 27. Manner of Death 1 Natural 2 Accident

1 npatient 28a. Date of Injury (Month, Day 5 ☐ Pending investigation 6 ☐ Could not be

Hospital:

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and itle of certifier my pm 29c. License number

MEN 1824 nd address of person who completed

29d. Date signed (Month, Day, Year) 07

cause of death (Item 23a) (Type, Print)

31. Date filed (Month AUG 0 3 2007

State Registrar

22. Name and Address of Facility

DeVol Funeral Home,

Month

29d. Date signed (Month, Day, Year)

August 3, 2007

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Approximate Interval Between Onset and Death

permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tronce. **Physician** /Medical

Physician

/Medical

Examiner

Funeral

Director

a or 28a-f show t be notified at

items 23a cliner must by

"natural", or iterredical Examiner

27 Is marked other er traumatic event, to

Director

Funeral

<u>\$</u>

Completed

Be

21. Signature of Funeral Servi

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examiner

the burial-tran attending physician for use as the huria ast been signed by the should be detached certificate has I rector, page 2 s director this funeral ours after death.

neral Director: A

The law requires that the death certificate be executed

or Attending Physician:

To the Hospital within 24 hours a

Division or Vital Records, P.O. Box 68760.

Physician/Medical Examiner

Completed by

Certification: To Be

10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. There is disease, or complications that caused the death shock, in a failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Conso (Final disease or condition resulting in death) Advanced Prostate Cancer Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (bisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4⊡Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Failure to thrive, Chronic Renal Failure, Tube 1 Yes 2 No 3 Probably 4 thunknown Feeding, Anemia, Candida Esophagitis 24a. Was an 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the date and place and place and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) and manner stated.

Shyamsundar Rajan, M.D. 9801 Georgia Avenue, #117, Silver Spring, MD 20902 31. Date filed (Month, Da

29b. Signature and title of certifier

Registrar's Signat

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

29c. License number

D53367

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Louise Ballard **Physician** Autonth 2007 Year 8:15A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 615 Silver Rock Road Lusby Calvert 7. Age (In yrs. last birthday) 8. Date of Birth Month Day Yand 12 If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 216 32 0671 6. Sex Funeral 9. Birthplace (State or Foreign Hours 1 ☐ M 2 ☐ 🗱 Months Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State Maryland 10c. City, Town or Location Lusby 10b. County Calvert 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Director 1 ☐ Yes 2X No 10f. Zip Code 20657 615 Silver Rock Road 10g. Citizen of What Country? United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: white 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify Completed by 3 Nidowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 administrator Bethlehem Steel Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LeRoy Johnson Mary Deny Tonque ပ 19a. Informant's Name/Relationship *(Type. Print)* Thomas Stevenson — sol 19b_Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 Silver Rock Rd. Lusby Maryland 20657 20b. Place of Disposition (Name of 20c. Location - City or Town, State Alexandria Virginia 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug 6 2007 Metropolitan Funeral Service permit. Pages 'Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee Brause P.B. Box 600 Lusby Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a # nsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 □ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) by the a 9□Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Wunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has e 2 certificate had irector, page 2 autopsy perform 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home SMResidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Charles Bennett, M.D. H. G. Trueman Road Lusby MD 20657 31. Date filed (Month, Day, Year) 32. Registras Signature State 2007 Registrar AUG

07-06201 Jo

Physician Physician 1 Decedent's Name (First, Middle, Last) 1 Decedent's Name (First, Middle, Maiden Name (First, Middle, Last) 1 Decedent's Name (Fir	hn Burroughs		Please Type or Print in Black Inc					lible.	
Discussion of the property of the control of the property of the p	nin Bonoogno		1- For State Cert			ieritai i iy	_	20	07 2661
Second Se	Physicia		Registrar				2. Date of Death	1	3. Time of Death
## Fischip Name of non-relations well-was and numbers \$40 Fisched Name of Na			John Allen	Ruri	coughs		Month August 12,	Day Year 2007	0629 hrs
3. 5. Size a Securin Namerical Security Namerical S	Minutes.		4a. Facility Name (if not institution, give street and number)		b. City, Town, or Locat	tion of Death		4c. County of De	
387-64-7848 1/4 2 50 1/4			543 Frederick Street	.1					
387-64-7848 \$\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)			8. Date of Birth		
To State Doc Carrier Total Name Tota	Director		387-64-7848 1 M 2 F 50	Yrs.	Morius Days	iouis iviiii.	Oct 26	1956	Country) Wisconsi
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State 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature				ner 111 F	enn Street, Baltir	more, MD	21201		
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DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and Me ertificate of Death		2007	2657
	9 3	10	Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Dea	Reg. No. (_ U U /	3. Time of Death
	Physici /Medi		Daniel Darrell Barnhouse, Jr.		AUGUST	Day Year	12:40 M
Ę.	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	107031	4c. County of Death	10110
			Washington County Hospital	Hagerstown		Washington	
A)	Funeral		5. Social Security Number 218_82_1279 6. Sex 1 7. Age (In yrs. last birthda)	Months Days Hours Min.	8. Date of Birth (Month, Day	v, Year) Countr	ace (State or Foreign y)
a de la constante de la consta	Director		Usual Residence of Decedent		Feb. 14	4,1970 Ohic)
	yland now at		10a. State 10b. County 10c. City, Town or I	ocation		100	d. Inside City Limits
	e Mar ta-f sl	ctor	Maryland Washington Williams	port			1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Countr	y?
	ath w	la	45 North Conococheague St.	21795		U.S.A.	
	ter de item iner n	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)		tc.
<u></u>	urs af al"; or Exami	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Whit	.e
12-0036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation se kind of work done during most of working		16b. Kind of Business/Indu	ıstry
7	ithin 7 ne. nan "u	ם	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
2	e filed w al Hygier I other th vent, the		10 Coo		/=	Restaurant	
land 2	iould be filed v I Mental Hygie narked other t natic event, th	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (,	
<u> </u>	2 should be and Ment is marked	2	Daniel Darrell Barnhouse, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mai	Deborah Ka			Cade)
Mary	nd 2 salth ar 27 is r trau		Joann E. Stouffer/friend	ling Address (Street and Number or Rural 7 Lappans Rd. Fairp	lay, Ma	ryland 21733	,ode)
ā,	E E B		20a. Method of Disposition 20b. Place of Disp	position (Name of Da ematory or other place)	te	20c. Location - City or Tow	n, State
Ē	Page nent c int; If iny or		Fig buildi 24st Cremation 3 Li Removal from State	urg crematory 8-8-2	2007	Smithsburg, I	Marviand
Baitimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Doug	glas A.	Fiery Funera	al Home
n	9 9 5 6 6	100	aney sano lon	331 Eastern Blvd. N			742
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or	respiratory arr	177	Approximate nterval Between
E	Physician		Immediate Cause (Final disease or condition resulting in death)	Ketoqq'dosi's		1	Onset and Death
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X D D	ath ce ttendi	hysician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of delivery Month D	/ Pay Year
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ŗ.	w requires that the death certific been signed by the attending p should be detached for use as	0	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute to the	cause of death?
cords,	uires I sign	d by		, gg	1 🗆 Y		
5	w req	lete			24a. Was a	24h Ware autono	sy findings available
ב	The law ate has b	Completed			autops perfor	sy prior to comp med? death?	oletion of cause of
U	ian: rtifica tor, p	BeC	25. Was case referred to medical	26. Place of Death (□ No
>	nysici nis cer direc	To B	examiner? 1 ☐ Yes 2 ☐ Ño Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other		ence 6 ☐Other (Specify)	
5	ng Pt fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury			ow injury occurred	
2	tendi eath. tor: A the fu	Certification:	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
<u> </u>	or At fiter d Direct in by	ığı	4 Homicide determined 28e. Place of injury - At home, farm, s	reet, factory, office 28	f. Location (S: City or Town	treet and Number or Rural F n, State)	Route Number,
-	of the Hospital or Attending Physician: within 24 hours after deals, of the Funeral Director; After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, ar	nd due to the e	causo(s) and manner as state	to d
	e Hog 24 h e Fur letely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	d at the time, o	date and place, and due to t	he cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Me	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Month, Da	ay, Year)
) West	D21457		8-6-200;	7
			30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)			
<u></u>	H-1		ABOUL WAHRED MD_ 1282	, Print) LI - OAKHILL AVE	HAC	ERSTUWY.	MD21740
	Sta Registr		31. Date filed (Month, Day, Year) 32. Begistrar's Signature AUG 1 0 2007	Lande			
			A CONTRACT AND ACTION ACTION AND ACTION AC				ļ

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** AGNES MARIE BANKHEAD /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NEWBURG 14580 SOUTH CUCKOLD CREEK ROAD If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min 1 ☐ M 2 1 F 81 579-28-9108 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State Director **NEWBURG** CHARLES MARYLAND 10f. Zip Code 10e. Street and Number 20664 14580 SOUTH CUCKOLD CREEK ROAD Funeral . Was Decedent Ever in U.S. Armed Forcas? 1 Yes 24 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 2 YEARS Elementary/Secondary (0-12) EEO INVESTIGATOR 17. Father's Name (First, Middle, Last) Be MAURICE SMALLWOOD ဥ 19a. Informant's Name/Relationship (Type. Print) BONNIE BANKHEAD / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) ature of Funeral Service Licenses LYDIA C. THORNTON JOHNSON MO0583 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of)

4c. County of Death **CHARLES** 8. Date of Birth
(Month, Day, Year)
JULY 29, 1926 9. Birthplace (State or Foreign MARYLAND 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) MARIE HILL SMALLWOOD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 255, NEWBURG, MARYLAND 20664-0255 Date 20c. Location - City or Town, State HOLY CHOST CHURCH CEMETERY AUGUST 11,2007 ISSUE, MARYLAND 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ELON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2. Date of Death

6,

2007

AUGUST

3. Time of Death

2:45 A M

Division or Vital Records, P.O. Box 68760,

Examiner

Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
₽	Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1
Completed			24a. Was an autopsy findings availab prior to completion of cause or death? 1 ☐ Yes 2 ☐ No
o Be Comple	25. Was case referred to medical examiner?	Line ritely Othor:	f Death (Check only one) ing Home 5□ Residence 6 □Other (Specify)
Medical Certification: To Be (27. Manner of Death Matural 5 Pending	be 28e Place of injury - At home farm street factory office	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Medical C	29a. Certifier (Check only one) Check only one)	Physician: To the best of my knowledge, death occurred at the time, date and caminer: On the basis of examination and/or investigation, in my opinion, death and manner stated.	place, and due to the cause(s) and manner as stated. occurred at the time, date and place, and due to the cause(s)
Me	29b. Signature and title of certifier	- H Holl D2f35	29d. Date bigned (Month, Day, Year)
	30. Name and address of person w	no completed cause of death (Item 23a) (Type, Print).	~ 2064G.
State	31. Date filed (Month, Day, Year) AUG 0	6 200 Slew & Sparle	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Day PAUL 2007^{ea} BORT August 11:16 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5 Midline Court Gaithersburg Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Months Days Hours 1**⊠**M 2□ F 217-46-6358 59 Aug. 21 1947 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Montgomery Gaithersburg 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Midline Court 20878 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Myes 2 No If Yes, Give Year or Dates: Vietnam 1 ☐ Yes 2 No White Specify: 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter 11 Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Redmond William T. Bort 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Bort / Brother 13210 Magellan Avenue, Rockville, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cemetery 8/7/07 Bethesda, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Muriel H. Barber Funeral Home muriel P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir very arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mu disease or condition resulting in death) Due to (or as a consequence of) OVONOW Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons a rence of): cottos Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2[1∐ Yes 26. Place of Death (Check only one) 1 | Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at show

r items 23a or 2 iner must be n

r than "natural", or iten the Medical Examiner

filed within 72 hours after death or Hygiene.

12 should be filed w π and Mental Hygiel 1s marked other th

permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important; if Item 27 Is marked other any injury or other traumatic event, if

Baltimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

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be execute burial-trar Records, P.O. Box 68760 physician the as attending for þ signed t page 2 s certificate ór Vital this

funeral director, To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Physician/Medical 2 Completed Be ဥ Medical Certification:

Examine

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No Other: 4 \sum Nursing Home Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ling Yang, M.D. 19529 Doctor's Drive, Germantown, Maryland 32 degistrar's Signature

2007 06 AUG

29c. License number

U0055374

29d. Date signed (Manth, Day, Year)

20874

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

anext item 19a per fib. 871 9-18-07 vt.
State of Maryand 1 Expartment of Health and Mental Hygiene

1 - Registrar

Certificate of Death

Reg. No. 2 1 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 3, 2007 \mathbf{P}^{M} Cecelia Benton 11:50 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Edenton Retirement Community Frederick Frederick if Under 1 Year | if Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 X F 076-12-8472 98 23, 1908 Pennsylvania Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number with 20882 25109 Silver Crest Drive USA Funeral death v Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. \$ 3 Nidowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 3 Own Home traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Andrew Golembiewski Frances Marchlewska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 is i 25109 Silver Crest Drive, Gaithersburg, MD 20882 Walter Marcus, son altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or conce. 1 ☐ Burial 2 DiCremation 3 ☐ Removal from State Metropolitan Crematorium8/7/2007 | Alexandria, Virginia 4 □ Dopation 5 Other (Specify) 22. Name and Address of Facility Molesworth-Williams PA Funeral Home 21. Signature of Funeral Service Licenses Krist 20872 26401 Ridge Road, Damascus, Maryland X 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia days /Medical Due to (or as a consequence of): **Examiner** Right Hip Fracture Sequentially list conditions, if any, sawing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner be executed burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical law requires that the death certificate the use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav for in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy perform 1 Yes 2 No certificate Division or Vital 25. Was case referred to medical examiner?
1 X Yes 2 No funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify Assisted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury unk. 28d. Describe how injury occurred subject fell. 27. Manner of Death 28c. Injury at Work? or Attending 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 📉 No 8/1/2007 6:00 fall while walking death. 24 hours after death Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, MD City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Nursing Home
Assisted Living Retirement à 4 Homicide filled in Assisted Living 5800 Genesis Lane, Frederick, Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifie D22101 August 6, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lloyd Halvorson, MD, 1475 Taney Avenue, Frederick, Maryland 21702

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 07

2007

Division or Vital Records, P.O. Box 68760,

			For State	State of N	Maryland		artment of H				_	21		00	571
		-	Registrar 1. Decedent's Name (First, Middle, La	act)		Cei	illicate of	Dealli		2. Date of De	Reg. No). L. U	- i	3. Time o	f Death
	Physici /Medic		Royal Henry Brou							Month		^{1y} 2007	'ear	5:00	
	Examin		4a. Facility Name (If not institution, given		er)		4b. City, Town, o				1	. County of			
			419 Russell Aven	ue, #320			Gaither				M	ontgo	mery		
	Funeral Director			Sex 7 1 ☐ M 2 ☐ F	Age (In yrs. lasi 81		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bird (Month, Da April 2	th V Year	1926	Birthp Coun New	lace (State of try.) York	or Foreign
111	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						1	0d, Inside C	ity Limits
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	he M 28a-f otifle	ectc	Maryland Montgome	ery	Gait	herst	10f. Zip Code				10a Ci	tizen of Wh	at Coun	try?	
	23a or ust be r	by Funeral Director	419 Russell Aven	ue, #320			2087	7				nited	Sta	ites	,
	tems	une	11. Marital Status	12. Was Deceder Armed Force	s?		Was Decedent of F If Yes, specify Cub	lispanic Ori an, Mexica	igin? (Spec n, Puerto F	cify Yes or No Rican, etc.)	-	14. Race - Black,	Americ White,		
36	rs affe	y F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date:	□№ 1943 s: 1945	-	1□Yes 2⊠No	Specify:				Specify:	Wh	ite	
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212	d with giene r tha the t	E O	Liementary/Secondary (0-12)	College (1-4d	7 5+)	Indu	ıstrial E	ngine	er		Avi	ation	Ind	ustry	
and	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or flems 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	To Be C	17. Father's Name (First, Middle, Las Russell Broussear							(First, Middle, ne Call					
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	-	19a. Informant's Name/Relationship Gloria C. Brouss	(Type. Print) eau/ Wife		19b. Mailir 419 F	ng Address (Street Russell A	and Number	er or Rural	Route Numb 20, Gai	er, City Lthe	or Town, Si rsbur	ate, Zip	Code) D 208	77
ē,	Pages 1 an nent of Heal int: If Item 2 iry or other		20a. Method of Disposition 1⊠ Burial 2 □Cremation 3 [☐Removal fro <i>m</i> Sta	1 ce <i>m</i>	eterv. crer	sition (Name of natory or other pla	с <i>ө)</i>	Augus	ate st 20,		ocation - C			
Baltimore,	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	1////	Calv		Nationa ery Name and Addre		2007 ty DeV					ew Yo	rk
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	Physician		Immediate Catse (Final disease or condition resulting in death)	_a	rdial I		tion								
	/Medical Examiner		Toodking in doddin	,	as a consequer osclero	,									
l.		7	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	as a consequer										
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Box	leath certifica attending ph	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne pf pregnanc		Ectopic pregnanc	V				23d. Date		,	
	e deat	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		t at time of deat		Other (specify)	,				Mont	h	Day	Year
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or Vital Records,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	ρ	Part II. Other significant conditions	contributing to deatr	1 Dut not resultir	ig in the ui	ngenying cause giv	en in Pari i	-	1 🗆 1				ably 4	
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0 _	ding Pi J. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of I (Month,	njury 28 Day Year)	3b. Time of Injury	Wo			28d. Describe	how inju	ury occurred	t		
Sio	Attending r death. ector: After by the fune	atic	2 Accident investigation 3 Suicide 6 Could not be					Yes 2							
Division	after de after de I Direct	Certification:	4 Homicide determined	20e. Place of	injury - At home etc. (Specify)	e, farm, str	eet, factory, office		2	8f. Location (a City or To			or Rura	il Route Nur	nber,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C		hysician: To the be miner: On the basis and manner	s of examination										s)
	To th within To th comp	Me	29b. Signature and title of certifie	SI		_	29c. Licens	se number			29d. D	ate signed (Month,	Day, Year)	
	^		1 NEW	U_	M		141	24	5		8	16	12	007	L
2	TIVIT		30. Name and address of person who Jack Richard Eps	completed cause o	of death (Item 23	Ba) (Type, O Cor	Print)	Aven	ue, E	Kensing	ton	, MD	2089	5	
	Sta	te	31. Date filed (Month, Day, Year)												
	Registr		AUG 0 7	2007	strar's Signatur	19									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2007 **Physician** August 13, рΜ C. 4:20 Anthony Bonanno /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care-Potomac Potomac Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min.

Month, Day, Year
Jan. 25, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F Months 577-12-6993 86 Ĩ921 Massachusetts Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c, City, Town or Location r 28a-f show notified at 10a State 10h. County 10d. Inside City Limits 1 Yes 2 □ No Directo Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e 4450 South Park Avenue, #819 20815 IISA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 K Yes 2 No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify. White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Barber Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carmelo Bonanno Grace Finocharo ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20815 Department of Health Important: If item 27 any Injury or other the once. 4450 South Park Avenue, Bess Bonanno/Wife #819, Chevy Chase, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 16, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Aspiration Pneumonia Weeks /Medical Due to (or as a consequence of): Examiner Weeks Dyschagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed End-Stage Parkinson's Disease \$1d inding physician and use as the burial-train that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cachexia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 K No 2 ER/Outpatient 3 DOA P After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 🔼 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a To the Hospital 29a. Certifier 🔁 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31319 August 14, 2007

x\

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Loreto Albiol, M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar AUG 1 5 2007

8218 Wisconsin Avenue, #305, Bethesda, MD 20814

Hospital or Attending Physician: The law requires that the death certificate be executed certificate

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** August 12/5PM Harry Childs, Jr. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 28,1931 5. Social Security Numbe 7. Age (In yrs, last birthday 9. Birthplace (State or Foreign Months Days Hours Min. $\stackrel{ ext{Douintry})}{ ext{D}} \stackrel{ ext{C}}{ ext{.}}$ 1 ☑ M 2 🗆 F 579-36-7998 76 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17810 Greentree Terrace 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 1 1 1 No 1947 − 5. If Yes, Give Year or Dates: 1951 − 53 1 Never Married 2 Married 2 No 1947-51 1 ☐ Yes 2 🛣 No Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) high voltage electrician naval research lab 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Childs, Sr. Thelma Robinson Stevens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Childs - wife 17810 Greentree Terr., Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hagerstown Crematory 8/8/07 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NEUMONTA ALBNIRED Community disease or condition resulting in death) Due to (or as a consequence of): SQUAMONS UNKNOWN CELL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DO MEMBRANOUS COLITIS 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO0 58181 MD. AUGUST 08 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 324 E. ANTIETAM ST. HAGERSTOWN # 306 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 08 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Charles Clinger, Sr. JUGUS1 James 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**XX**M 2□ F Director 200-22-0301 78 June 10,1929 Pennsylvania Usual Residence of Decedent 10a. State 10b County 10c City Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2XXNo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17322 Diane Drive 21740 12. Was Decedent Ever in U.S. Armed Forces?

1 TYPES 2 No 194 If Yes, Give Year or Dates: 1950 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married 1947-3altimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify þ 3 ☐ Widowed 4 ☐ Divorced Specify. 1950 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mail Handler Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Philip R. Clinger Alberta Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lena Clinger - Wife 17322 Diane Drive Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Spe Aug. 11,2007 Williamsport, Maryland Greenlawn Mem. Park 21. Signature of Funeral S OSBOTTE AFTER FRITY Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical quence of) Examiner Sequentially list conditions, if any call good and late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed physician and strans the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical ası IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year i signed by the ail 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9□Unknown 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tyes 2 No 3 Probably 4 □Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has e 2 s this certificate 1☐ Yes 2 DN0 or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 N ပို 1 ☐ Inpatient 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 2 ☐ Accident 6 ☐ Could not be 3∏ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

WH5+1

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

AUG 1 0 200

0/

32. Registrar's Signature

The WA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. Sperke

11111

21742

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

AUG 0 6 2007

INDEN

82

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 _ For State

of Death	7	Yea	ar	3. Tim		ath
Reg. No.	2	UL		9	61	1
, 3	-					

Phy	sician	
/M	ledical	
Exa	miner	
	- 5	

Funer Direct permit. Pages 1 and 2 should be illed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physicia /Medica Examine

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760, Registrar DHMH 17 Rev 1/2001

1 Decedent's Name				uncate of	- 00011	Re	J. No.		1 10 10 /	
	(First, Middle, Last) unche T.	Coo	per			2. Date of Death JM1y 31,	5.0	Year	3. Time of Death 9:43P M	
4a. Facility Name (If I	not institution, give street and aryland Hospital	f number)		4b. City, Town, c	or Location of Death	1	4c. Count	of Death	e's	
5. Social Security Nu 124–16–3088	3 1□ M 2 X	7. Age (In yrs. 81	la <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 25,	1925	9. Birthpl Count IVE	ace (State or Foreig ry) W Jersey	
Usual Residence of E	Decedent 10b. County	10- 04	. T							
	Prince George's		, Town or Loc . Washin					10	0d. Inside City Limits 1 □Yes 2010	
Maryland 10e. Street and Number 9103 Branch	oview Drive			10f. Zip Code 20744		109	10g. Citizen of What Country? USA			
11. Marital Status 1 □ Never Marrie 3 ☒ Widowed 4	d 2 ☐ Married	Decedent Ever in U. d Forces? es 201 No , Give or Dates:	If	/as Decedent of H Yes, specify Cub	lispanic Origin? (S) an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		ce - America ck, White, e y: Blac	tc.	
(Specif	5. Decedent's Education y only highest grade complete		16a. Decede	ent's Usual Occup	ation	king 16	b. Kind of B	usiness/Ind	ustry	
(Specification of the second o		ge (1-4or 5+)		nenaker menaker	during most of word	King	In	Home		
17. Father's Name (F					18. Mother's Nam Hele	ne (First, Middle, Ma en Askew	iden Surnar	ne)		
19a. Informant's Nan	ne/Relationship (Type. Print) Bailey / Daugh	ter	19b. Mailing 3950 S	Address (Street Senior La	and Number or Ru a. Sandst	ral Route Number, on , VA . 2	City or Town,	State, Zip (Code)	
20a. Method of Dispo		20b. P	lace of Dispos emetery, crem	ition (Name of atory or other place	ce)	Date 20	c. Location	City or Tov	vn, State	
4 □ Donation 5	Other (Specify)		verton	Nat. Cen	n. 8/6/				w York	
21. Signatur Fund	P Kalso		6.	Name and Addre	^{ss of Facility} Geo ill Road Ox	rge P. Kala on Hill, Ma	s Funer ryland	al Home 2074		
23a. Part1. Inter the shock or heart Immediate Cause (Fi disease or condition resulting in death)	a	at caused the death on each line. Out to or as a consequ	my E	the mode of dyin	ig, such as cardiac	or respiratory arres	t,		Approximate Interval Between Onset and Death	
Cause. Enter Onders Cause (Disease or inj that initiated events resulting in death) Las	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c									
IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 □ 9 □ Unknown	onths? 1□Li	outcome pf pregna ve birth 2 ☐ Fetal egnant at time of de iknown	death 3□E	ectopic pregnancy Other <i>(specify)</i>	,			e of deliver	/ Day Year	
Part II. Other signification	ant conditions contributing t	o death but not resu	Iting in the unc	lerlying cause give	en in Part I.	23e. Did tobac	cco use cont		cause of death?	
in the past 12 m 1 Yes 2 Yes 9 Unknown Part II. Other signification						24a. Was an autopsy performe	d? (leath?	sy findings available pletion of cause of	
25. Was case referred examiner?					26. Place of Deat	h (Check only one)		· -	<u> </u>	
25. Was case referred examiner? 1 Yes 2 No	Hospital: 1	npatient 2 ☐ E	R/Outpatient	3 DOA Othe	er: 4 🗆 Nursing Ho	ome 5 Residenc	e 6 □Oth	er (Specify)		
27. Manner of Death 1 Natural 2 Accident 3 Suicide		ate of Injury fonth, Day Year)	28b. Time of Injury	28c. Injury Work M 1	/ at	28d. Describe how				
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	determined 288. Pl	ace of injury - At hor illding, etc. (Specify	ne, farm, stree)	t, factory, office		28f. Location (Stree City or Town, S	t and Numb State)	er or Rural I	Route Number,	
29a. Certifier 11 (Check only one) 29b. Signature and titl	Certifying Physician: To Medical Examiner: On the and m	the best of my knove basis of examination	vledge, death on and/or inve	occurred at the tin stigation, in my o	ne, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and ma and place,	nner as sta and due to t	ted. he cause(s)	
29b. Signature and titl	e of conffier			29c. License	number	29d.	Date signed	(Month, Da	ay, Year)	
1 hilly	1, Eleven	\sim		03	<i>F</i>	lugus	August 3, 2007 -t WARKINGTON, maylond			
00 20, 00	•									
30. Name and address	s of person who completed c		23a) (Type, Pr	int)	Rond 1	Fat WARH	ington	mr	yland	

07-06167	
William Cooper	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Villiam Cooper	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year
wedical Examine	WILLIAM P. COOPER 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Peninsula Regional Medical Center Salisbury Wicomico
Funeral Director	5. Social Security Number 218-74-2809 6. Sex 1X M 2 F 41 Yrs. 41 Yrs. 41 Vrs.
a way	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
*	DELAWARE SUSSEX DELMAR 1 Yes 2 X No
the Marylanc a or 28a-f sh tified at onc	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37944 JOHNS WAY 19940 IJS
	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
fter death !", or iten er must l	Armed Forces? Armed Forces?
72 hours, al Exami	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural" injury or other traumatic event, the Medical Examine To Be Completed by	Elementary/Secondary (0-12) 12 College (1-4 or 5+) DISABLED 18. Mother's Name (First, Middle, Last)
215- be filed ntal Hyg rked of ent, the	
Tore, MD 2121 ges 1 and 2 should be fi nn of Health and Mental t. If item 27 is marked other traumatic event, To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA SMALLWOOD 25385 SOUTH OAK DRIVE, MILLSBORO, DE, 19966
e, MD 1 and 2 sho Health and item 27 is	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
imor Pages nent of ant: If	Burial 2 X Cremation 3 Removal from State MELSONS CAPE HENLOPEN 4 Donation 5 Other Specify: CREMATORY 8-12-2007 FRANKFORD, DELAWARE
Baltimo permit Page Department o Important: injury or oth	21/ Figurature of Funeral Servicensee MELTSON AFTUNERALLY SERVICES, LTD. 43 THATCHER ST, FRANKFORD, DELAWARE. 19945
Physician /Medical	23a. Part). Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death) a Complications of scalding Due to (or as a consequence of):
<u></u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
ed nsit	Cupisease or injury that initiated
outed ransit	events resulting in death) Last Due to (or as a consequence of): d.
60, ate be execut hysician and e burial - tra	X UNPENDED AMENDED AMENDED PII,27,28a-f, perME,g872, 10/2/07 TT
	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
). Box 687, the death certification by the attending placed for use as the Physician/	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown
Records, P.O. Box The law requires that the death cate has been signed by the arte page 2 should be detached for to completed by Physics	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Is, P.C quires that en signed luid be deta	Seizure disorder 1 Yes 2 No 3 Probably 4 V Unknown 24a. Was an 124b. Were autopsy findings available
of Vital Records, ag Physician: The law requires the this certificate has been signeral director, page 2 should be not To Be Completed n: To Be Completed	autopsy prior to completion of cause of performed? death?
	25. Was case referred to medical 26.Place of Death (Check only one)
n of Vital F ding Physician: h. After this certifi funeral director, on: To Be C	examiner? 1 Ves 2 No
ᆮᇶᆠᄰᅵᅙ	27. Manner of Death 28a. Date of Injury (Month, Day,Year) Red. 8/1/2007 1 Yes 2 X No Subject was scalded
Division o spital or Attending ours after death. neral Director: Aft filled in by the fune Certification:	2 X Accident Investigation Prior O/ 1/2007 UIIK 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Divis Divis the Hospital or At hin 24 hours above the Funeral Direct appletely filled in by lical Certific.	4 Homicide determined (Specify) found at home 37944 Jones Way Delmar, DE
Division To the Hospital or Attention 24 hours after death To the Funeral Director: completely filled in by the	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To with To com	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	Fatt Gronica Tollath - O.C.M.E. August 12, 2007
	30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registrar	31. Date filed (Month, Day Year) 3 2007 32. Resistrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July **Physician** 2007 Lindsay E. 11:15 A M Crabtree /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 27,1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 510-03-1382 1X M 2□F 84 MÓ Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 X No MD Montgomery Germantown Director e filed within 72 hours after death with the I all Hygiene. other than "natural", or items 23a or 98a-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 11304 Corinthian Court 20876 United States "natural", or items 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married WW II Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify: White Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Printer Government 7 is marked other traumatic event, 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental ! Erie Crabtree Iva Richards မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 20066 Appledowre Circle, Germantown, MD 20876 Vicki L. Crabtree / Daughter item 27 other ti 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Parklawn, Memorial Parklawn, Memorial Park Department of Important; If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11 4 Donation 5 Other (Specify) Rockville, MD 21. Signature of Funeral Service Li 22. Name and Address of Facility 2. Name and Address of Facility DeVol Funeral Home, 10 Deer Park Drive, Gaithersburg, MD 20877 Y RACU Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acute Myocardial Infarction Physician days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Acute Chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Congestive Heart Failure death certificate be execute nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Completed by Physician/Medical Diabetes Mellitus IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an nas autopsy perform or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA Certification: To 1 🕅 Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 27. Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 31, 2007 DOO 62 30. Name and address of person who completed Petek Donmex , M.D., cause of death (Nem 23a) (Type, Print) 11119 Rockville Pike #401, Rockville, MD 20852 31. Date filed (Month, Day, Year) AUG 7 2007 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 7:12 A M Pame1a Ann Cochran August /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 12531 Quiet Stream Court Frederick Mt. Airy If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛛 F Director 212-98-8792 40 Nov. 3, 1966 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Mt. Airy Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12531 Quiet Stream Court 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Government Space Management Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Bird Burton Shirley Lee Bryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gilbert J. Cochran, Jr./ Husband 12531 Quiet Stream Court Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 Other (Specify) Stauffer Crematory 2007 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of rat Service Lidense 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the sahould be detached it 1 ☐ Yes 2 ☑ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 25 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1□ Yes 2□ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 ☐ Pending investigation after death.

I Director: Ald in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and this of certific 29c. License number 29d. Date signed (Month/Day, Year)

State Registrar 1502 S. Main Street Mt. Airy, Maryland 21771

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

Hope A. McIntyre, M.D.

AUG

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 7:15 2007 August 6, SARAH DAUGHERTY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Worcester Pocomoke City Hartley Hall Nursing Home 1 Year If Under Days Hours Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🕶 F 78 Aug. 3, Maryland Director 215-26-5933 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 Yes 2 No Director Pocomoke City MD Worcester 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ral", or items 23a or Examiner must be USA 21851 4417 Stockton Road Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or items 23a uny or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2K No Specify: Baltimore, Maryland 21215-0036 Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foods Production Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virgie Killmon P William J. Dukes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4417 Stockton Rd., Pocomoke City, MD 21851 Gordon T. Daugherty (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 8/10/2007 Stockton, MD Portersville Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Holloway Funeral Home, Professional Association 21. Signature of Funeral Service Licensee 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physlcian: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After Injury 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely

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BA4 State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

29b. Signature and tile certifier

Tt. ocom gistrar's Signature

29c. License number

54422

21851

29d. Date signed (Month, Day, Year)

8-7-2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 8/1/2007 **Physician** 0120 Albert Bertram Doyon Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/03/1919 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□F ntry) NH 003-09-7459 87 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a, State 10d. Inside City Limits 1 ☐ Yes XXNo Anne Arundel Annapolis Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 21401 USA 2565 Golfers Ridge Rd. ms 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items 11 Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1946-White 1 ☐ Yes 2 🛣 No Specify: Completed by 3 Midowed 4 Divorced 1964 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Army Intel Lt. Col 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dora M. Pellerin Joseph Charles Doyon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, MD 21403 3700 Thomas Point Rd. Albert B. Doyon Jr. Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/2/2007 Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee atri 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary **Physician** ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ner The law requires that the death certificate be executed Exami burial-trar Due to (or as a consequence of) Physician/Medical the attending physical at the second IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ. 1 🗌 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' αeatn? 1∐Yes 2∐No 1□ Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death the Funeral Directory filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier To the Fune completely f To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier reable, MD D46052 8/2/07

State

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a hwy, and policy of the person who completed cause of death (Item 23a) (Type, Print) a hwy, and policy of the person who completed cause of death (Item 23a) (Type, Print) a hwy, and policy of the person who completed cause of death (Item 23a) (Type, Print) a hwy, and policy of the person who completed cause of death (Item 23a) (Type, Print) a hwy, and the person who completed cause of death (Item 23a) (Type, Print) a hwy, and the person who completed cause of death (Item 23a) (Type, Print) a hwy, and the person who completed cause of death (Item 23a) (Type, Print) a hwy, and the person who completed cause of death (Item 23a) (Type, Print) a hwy, and the person who completed cause of death (Item 23a) (Type, Print) a hwy, and the person who completed cause of death (Item 23a) (Type, Print) a hwy, and the person who completed cause of death (Item 23a) (Type, Print) a hwy, and the person who completed cause of death (Item 23a) (Type, Print) a hwy, and the person who completed cause of death (Item 23a) (Type, Print) a hwy, and the person who completed cause of death (Item 23a) (Type, Print) a hwy, and the person who completed cause of death (Item 23a) (Type, Print) a hwy, and the person who completed cause of death (Item 23a) (Type, Print) a hwy, and the person who completed cause of death (Item 23a) (Type, Print) a hwy, and the person who completed cause of death (Item 23a) (Type, Print) a hwy, and the person who completed cause of death (Item 23a) (Type, Print) a had a h

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 5, . ^D2007 **Physician** 3:30 A Mona Faye Dueno /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ft. Washington Prince George's 10 Arthur Drive E. 8. Date of Birth Sept. 0, 1932 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 📈 74 Kentucky Director 578-42-4131 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Prince George's Ft. Washington 1 Yes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Arthur Drive E. 20744 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes ②∑No If Yes, Give Year or Dates: 1 Never Married 2XX Married 1 ☐ Yes 2 Ho White Specify. 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethe1 Dawson Foster Page 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Arthur Drive E. Ft. Washington, Maryland Hernani Dueno / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State August 10,2007 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature Juneral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Pah1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one complications that caused the death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 004 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ XXO Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate I 1∐ Yes Physiclan: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ⚠ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 or Attending XX Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 24 hours after death Pruneral Director: filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated соmpletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 46046 August 5, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD A.M. Alikhani 11711 Livingston Road Ft. Washington, Maryland 20744

State Registrar 31. Date filed (Month, Day, Year)

AUG 0 6 2007

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

32. Registrar's Signature

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MD 21215-0036 Id 2 should be filed within 72 hours affiltin and Merital Hygiene. In 27 is marked other than "natural ainmatic event, the Medical Examin	7)	Donald Wayne Dal	y, Jr. S	on	6661 E	ucknell	Road,	Bryans F	Road, Md.	20616
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Vit hysici this o	To B	1 Yes 2 No	1		R/Outpatient			rsing Home 5		Other:
1 of Jing Ph L. After t funeral		27. Manner of Death 1 X Natural 5 Pending	28a, Date of Inj (Month, Day,	ury Year) 28	8b. Time of Inju		at Work?	28d. Describe	how injury occurred	
Sior Attend death ector: by the	cati	2 Accident Pending Investig	ation	nium. At hom	o form street	factory, office bu		28f Location (Street and Number	or Rural Route Number, City
Division of Vital Records, plus for Actional Physician: The law requiremental death. After this certificate has been stilled in by the funeral director, page 2 should the control of the	Certification:	3 Suicide 6 Could n	ot be	njury - At nom	e, iaiii, sileei,	lactory, office be	iliding, etc.	or Town, S		or real areas realises, only
1 E E E E		4 Homicide	ician: To the best of n	ny knowledge	death occurre	d at the time, dat	te and place. a	and due to the caus	se(s) and manner a	s stated.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examin	ner:On the basis of exa	amination and/	or investigation	n, in my opinion,	death occurre	ed at the time, date	and place, and due	e to the cause(s)
F W E	Me	29b. Signature and title of certifier	and mainter stated	·		29c. License	number		29d. Date signed	(Month, Day, Year)
		Marchine On	elkull			O.C.N	1.E.		August 11, 2	2007
		30. Name and address of person wh						B 04653		* * - ·
1185			Assistant Medica			n Street, Ba	utimore, M	U 21201		
St Regist	ate trar	31. Date filed (Month, Day Year)	2007 32. Refistr	ar's Signature	y Ana	de				

State Registrar AUG 0 6 2007

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32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1 O A U G Physician ENGEL MURIEL 2007 2:56 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NATIONAL INSTITUTES BETHESDA Under 1 Year | If Under 24 Hrs. OF HEALTH MONTGOMERY 8. Date of Birth Feb. 13, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Brooklyn, NY 1 M 2 TF 075-20-0595 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygjene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f sh t be notified Silver Spring 1 ☐ Yes 2 XNo Maryland Montgomery Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20910 United States 8750 Georgia Avenue, #503B ms 23a o 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 22 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 Divorced tal Hygiene. d other than "natura event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Records Librarian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bachrack Harry Goodman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health a
Important; If item 27 Is
any injury or other trau 313 Highland Terrace Prince Frederick, Md. 20678 Edward M. Engel -son 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 8/18/2007 | Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner MYCOBACTERIA LUNG DISCASE CM. AVIVA The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, 20d Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ğ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 Yes 2 No 2 □ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ၉ 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 atural 5 Pending 1 □ Yes 2 □ No investigation within 24 hours after deam.

To the Funeral Director; / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10/20

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State

Registrar

M. HOLLAND, MD

AUG 1 5 2007

32. Registrar's Signature

STEVEN

31. Date filed (Month, Day, Year)

10 CENTER DRIVE, BETHESDA,

MARYLAND 20892

			For State Registrar		State of	Marylan	•	artmen <i>tificate</i>			nd Me	ental Hyg	jiene	07	256	89
	Physici	an	1. Decedent's Name (Fire	st, Middle, La	st)							2. Date of Dea Month	th Day	Year	3. Time of	Death
	/Medic			Brown	Fra							August	7, 200		9:10) A ^M
4	Examir	er	4a. Facility Name (If not			ber)				Location of	Death		4c. County			
			17727 Crest 5. Social Security Number			. Age (In yrs. I	act hirthday)	Hage If Under	rsto	Wn If Under 2	4 Hrs.	8 Date of Birth	Wash		on place (State o	r Foreign
	Funeral Director		265 - 14 - 8089		M 20F	82	Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day	Year) 2 1925	COL	intry)	ir roreign
			Usual Residence of Dec	edent		0 91						January		IVEW	TOLK	
	anylan ehow	L	10a. State 10b	. County		10c. City	, Town or Lo	cation							10d. Inside Ci	
	8a-f	ecto	Maryland W	ashing	ton	Hage	erstown								1 🗌 Yes	2/1/10
	with th	Funeral Directo	10e. Street and Number					10f. Zip					I0g. Citizen of \	What Cou	intry?	
	eeth ne 23,	erai	17727 Cre	st Dri	VE 12. Was Deced	ent Ever in II	S 13 1		740	spanic Orio	in? (Spec		U.S.A.	e - Amer	ican Indian.	
10	fter d	Fun	1 Never Married	2 Married	Armed Ford	es?				n, Mexican,	Puerto P	cify Yes or No- Rican, etc.)		ck, White		
5-0036	72 hours after deeth with the Maryland "neturel", or Iteme 23a or 28a-f show idical Examiner must be notified at	þ	3 Widowed 4	/	If Yes, Give Year or Dat	_		1 □ Yes	2/2/40	Specify:			Specify		ite	
5-0	72 hours "neturel",	Completed		Decedent's E	ducation ade completed)		16a. Deced	ient's Usua	I Occupa	ition uring most	of workin	ag.	16b. Kind of B	usiness/li	ndustry	
2121	- 1 2	ig.	Elementary/Secondary	, · ·	College (1-	4or 5+)	life. I	DO NOT us	se retired))		9				
	should be filed withir nd Mental Hygiene. marked other then imatic event, the M	S	12 17. Father's Name (First,	Adiddle Leet				Sal		10 Mathar	da Maria	/Circl Middle	Real Maiden Surnan		te	
Maryland	ould be fi Mental F arked ot atic ever	Be	John H. Fr		,						nche			10)		
Z	hould of Men marke	ဌ	19a. Informant's Name/F		Type Print)		19h. Mailir	n Address	(Street a				gess r, City or Town,	State 7	in Code)	
E	nd 2 shoulth and 27 le my r traum		Janet E.										MD 217		<i>p</i> 0000)	
ē,	Hear Hear Sthe		20a. Method of Disposition	on			lace of Dispo	sition (Nan	ne of			ate	20c. Location -		own, State	
Ę	Pages ent of nt: If if		1 □ Burial 2 🗖 Cre 4 □ Donation 5 □	emation 3 [Other (Specif]Removal from S v)	tate	ithsbu:	-		1	/8/20	007	Smithsb	ura	Marul	and
Baltimore,	permit. Page Deportment Important: If any injury of		21. Signatus Funeral			1 01113							Funera			and
œ	Dep Impo		1 Com	Tal	Sun								rstown			1742
	Physician /Medical Examiner	er	23a. Part1. Enter the dis shock, or heart fail immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate the condition of the con	ns.	a. Employed a Court of Court o	HYSE	ince of):	AN TER					NC 47.	Ñς	Approximate Interval Bet Onset and I	e ween Death
	uted d ansit	m I	cause. Enter Underlying Cause (Disease or injury that initiated events	~	REA	JAI.	INSC	111	CIE	NU	•			(EAR	57
ó	ate be executed hysicien and the burial-transit	resulting in death) Last Due to (or as a consequence of):									- 5	t				
3760,	ate be nysici he bu	<u>3</u>														
O. Box 68	law requires that the death certifica as been signed by the ettending ph. 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregin the past 12 mont 1 Yes 2 No 9 Unknown			th 2 ☐ Fetal nt at time of de	death 3	Ectopic pr Other (sp						te of deliventh		Year
٥	res that igned b be deta	by Pt	Part II. Other significant	conditions	contributing to dea	ith but not resu	ılting in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco use con	tribute to	the cause of d	leath?
g	quire an sig	ed b										1 🗆 Y	es 2 No	3 🗆 Pro	bably 4 🗆	Jnknown
al Records,	The ate h page	Completed									_	24a. Was a autop perfor 1 Yes	sy med?	Were aut prior to c death? 1 Yes	opsy findings ompletion of c 2 \(\text{No} \)	available ause of
Vital	Physician: this certific ral director.	Be C	25. Was case referred to examiner?	medical	Hospital:		5D(0-11		Othe			Check only				
o	Physic representations of the second of the	To :c	1 Yes 2 16		28a. Date of (Month	patient 2 🗆 I	28b. Time of		8c. Injury Work	4 🗆 Nur			ence 6 Oth		ify)	
io	Attending or death. ector: After by the fune	ation	1 Natural 5 [2 ☐ Accident	☐ Pending investigation		, Day Year)	Injury	М		:? ′es 2 □ N	lo					
Division	in Dir	Certification:		Could not b determined	280. Place C	of Injury · At ho g, etc. (Specify	me, farm, str	eet, factory	r, office		2	8f. Location (S City or Tow	treet and Numb n, State)	per or Ru	ral Route Num	iber,
	the Hospital hin 24 hours of the Funeral upletely filled	Medical	(Check only 2	Medical Exar	nysician: To the base and manner	sis of examinat	wiedge, death ion and/or in	vestigation	, in my op	inion, death	l place, a h occurre	d at the time, o	late and place,	and due	to the cause(s	;)
	Vaith Con	4	29b. Signature and title	of certifier	Wad	552		0	License	120C	13		Sed. Date signe	(Month	, Uay, Year)	
ال	41+1		30. Name and address of DWIGHT	WOOS.	ter 111	10 Me	dica	Print) Ca	mpl	is Ro	1. <i>H</i>	lagers	town	MD	2174	12
	Sta Registi		31. Date filed (Month, Da	3 1 0 2		gistrar's Signat	1 /_	a. M. s				J				

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ORIGINAL

		For State Registrar	State of Maryla		artment rtificate			-	Reg. No	1001	26691
Physicia /Medic	_	1. Decedent's Name (First, Middle, Las Charlotte	E .	F1c	oyd			2. Date of De August 2		7 Year	3. Time of Death 12:53 A
Examin	er 8.	4a. Facility Name (If not institution, give 11400 Ft. Washington	Road				ocation of Dea			County of Deat Prince G	eorge's
Funeral Director		5. Social Security Number 579–24–4970 1 Usual Residence of Decedent	7. Age (In yn	s. last birthday) Yrs.	If Under Months	1 Year Days	Hours Min		rth ay, Yea <i>r)</i> , 1926	9. Birt Co Wa	hplace (State or Foreig untry) Shington, DC
28e-f ehow		10a. State 10b. County Maryland Prince Geo		Ft. Was		n					10d. Inside City Limit
	Funeral Director	10e. Street and Number 11400 Ft. Washington	Road		10f. Zip	Code 207	44		10g. Cit	izen of What Co USA	untry?
- 3	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 Ā No If Yes, Give Year or Dates:		Was Decedif Yes, spec		panic Origin? , Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	0-	14. Race - Ame Black, White Specify:	
r than "netur	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 11th		(Give	dent's Usua kind of won DO NOT us Countant	k done du e retired)	ion iring most of w	orking		ind of Business/ r Force	Industry
Mental riyg tarked othe tatic event,	To Be C	17. Father's Name (First, Middle, Last) Samuel Berry					Go		aum		
n 27 ie m		19a. Informant's Name/Relationship (7 Vicki Goldsmith / Daug	ghter	8402	Heather	wick	Drive Br	andywine,			
nt: If iten ry or oth		20a. Method of Disposition 1 ⊞Burial 2 □ Cremation 3 □ 4 □ Donation		Place of Dispo cemetery, crei cyland Ve				Date 07/2007		cation - City or tenham, M	
Department of Hearing Important: If item 27 is eny injury or other tre		21. Signature of uneral Service Licen	les h	22				eorge P. Ka Oxon Hill			ome PA 0745
ysician ledical aminer	Examiner	23a. Part I Enter the disease, or comy shock, or heart failure. Ist only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consect.	Conceptual control of the control of							Approximate Interval Between Onset and Death
nysicie he bu	cai	resulting in death) Last	Due to (or as a conse	equence of):							
by the attending pl tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal déath 3 🛚	Ectopic pre Other (spe					23d. Date of del Month	ivery Day Year
engi pe o	Ď	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	nderlying ca	iuse giver	in Part I.		tobacco u	_	the cause of death?
ate has been si page 2 should I	Completed							24a. Was auto perfi 1 Yes	psy ormed?	24b. Were au prior to death?	topsy findings availab completion of cause of 2 \square No
certifi	Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2\(\text{XNo}\)	Hospital:	7		0.00		eath Check only			
After t funera	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	IER/Outpatier 28b. Time o Injury		Bc. Injury a Work?	4 Linuising	Home 5 XX Res 28d. Describe			cify)
To the Funeral Director: completely filled in by the	Certification;	3 Sutcide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory,	, office		28f. Location (City or To			ral Route Number,
he Funer pletely fill	edicai	29a. Certifier (Check only one) 1 Cartifying Ph	ysician: To the best of my kr inner: On the basis of examinand manner stated.	nowledge, death nation and/or in	h occurred a vestigation,	at the time in my opi	, date and place nion, death occ	e, and due to the curred at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
Tot	agents I	29b. Signature and title of certifier William V and	ney			License		.t wash		te signed (Monti	
		30. Name and address of person who c	completed cause of death (Ite	am 23a) (Type,	Print)		_		17		

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 200⁷ 14:43 Pm Myron Frosh /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery 7. Age (In yrs. last birthday) 86 yrs. 9. Birthplace (State or Foreign Country)
Colorado 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Jan 21,1921 6. Sex **Funeral** Months Days Hours 1 XM 2 □ F 521-28-4076 Director Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show the notified at 10a, State 10b. County 10d. Inside City Limits Maryland Montgomery Rockville 1 X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10401 Grosvenor Place 20852 United States permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hyglien and instural; or Items 23a a Important: If Item 27 is marked other than "natural; or Items 23a any Injury or other traumatic event, the Medical Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 🗓 No White Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (2)12) College (1-4or 5+)4 Salesman Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Frosh Anna Wabeck ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Frosh -nephew 4810 Gratham Avenue Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 8/10/2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, 4400 Powder MIII Road Beltsville, 21. Signajure of Funeral Service Licenses Maryland 20705 23a. Part1. Enter the disease, or complication at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FIBRILLATION **Physician** VENTRICULAR /Medical Due to (or as a consequence of): Examiner ORONAR Securitially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes To the Hospital or Attending Physician: The law requir within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No autopsy 2 No Vital 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2) 100 ဂ္ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 □ DOA o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) no, mD 00057124 8/10/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Truong Bao, M.D. 9715 Medical Center Drive, #201 Rockville, Maryland 20850 1902 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State AUG 1 5 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 870, 8-29-07 vt. State of Maryland Department of Health and Mental Hygiene 1- State Amend Items 23a, 25, 27, 28a-f per ME 873, 11/19/07dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Chong Ok Gonzales Month Day Year **Physician** 7 2007 /Medical YOUTUNE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UMMC Saltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Year 1 □ M 2 1 3 4 5 63 573-37-1994 1/6/1944 Director Koréa Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 □Yes 2FTNo Director MDAnne Arundel Hanover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21076 USA 1479 Gesna Dr. death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite I □Yes 🏋No fYes, Give Year or Dates: 1 ☐ Never Married 2 Married Korean altimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ĝ 12 Homemaker Own Home traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event once. Be Mai Yun 0 Cha Am Kim 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Husband 1479 Gesna Dr. Hanover, MD 21076 Ricardo Gonzales Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial ŽŽCremation 3 ☐ Removal from State Metro Crematory 8/2/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee Satral 12 Ridgely Ave. Annapolis, MD 21041 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Intracvania disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atlantoaxia Sequentially list our differs, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Vital Records, P.O. Box 68760, Physician/Medical the attending p use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Day 4☐Pregnant at time of death 9☐Unknown signed by the a d be detached for 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? ate has page 2 s autopsy performe 2 🖸 No 1 ☐ Yes 2 ☐ No 1∏ Yes Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division or 28a. Date of Injury FOUND th, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 ■ Natural FOUND 5 ☐ Pending investigation Probable fall. Unknown 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 1479 Gesna Drive determined 4 ☐ Homicide Home Hanover, MD To the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D61107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, Baltimore, MD Amelia Gr 31. Date filed (Month, Day AUG 0 strar's Signature State 3 2007 Registrar

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DIVISION	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to the Funeral Director: After to completely filled in by the funeral Director.	Certification:	3 ☐ Suicide 6 ☐ C	ould not be etermined	28e. Place of injubulding, etc.	iry - At hom c. (Specify)	ne, farm,	street, fa	actory, office		28	f. Location (City or To	Street a wn, Sta	and Numbe te)	er or Rural	Route Number,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26594 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Martha Ann Hutson 2007 5:50 PM August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N M S Healthcare Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 1 F 68 220-34-0562 11/07/1938 Director MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Hamilton Blvd. 21742 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Vice President Banking permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ottie Bell Baker John Keifer Crilley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Hamilton Blvd. Hagerstown, MD 21742 19a. Informant's Name/Relationship (Type. Print) Randal G. Hutson / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 08/13/2007 | Hagerstown, MD Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence f): /Medical Examiner cancer Breas Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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State Registrar

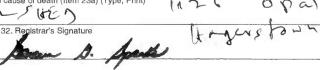
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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and 2	ertra	Leilani Assante/Daughter 5009 Ravenswood Rd. Rive: 20a. Method of Disposition 20b. Place of Disposition (Name of cemelery, crematory or other place) Date							iverda:	le,	MD. 2	0737	!					
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perm Depa	any ii		21. Signature of Funeral Service Licensee 22. Name and 1ddress of Furity and Home, Inc. 4217 9th St. N.W. Washington, D.C. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												C.	20011		
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		For State Registrar	State of Mary	•	ertificate of l			giene Reg. No. 🥎 🕦	-	2000
Physici	an	Decedent's Name (First, Midden RONALD	H. HOUSTON				2. Date of De Month AUGUST	Day	Year 2007	3. Time of Death' 7:30 a M
/Medic		4a. Facility Name (If not institution			4b. City, Town, o	r Location of De		4c. County		7.30 a
Examin	ier	4607 22nd Ave 5. Social Security Number		yrs. last birthday	Mt. Ra	inier		Prince	e Geo	orges
Funeral Director		226-52-3995 Usual Residence of Decedent	1⊠M 2□F 67	Yrs.	Months Days	Hours Mi	Nov.	1939	Cour	ginia
hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	_	10a. State 10b. Count	,	C. City, Town or L					1	10d. Inside City Limits 1 ☐ Yes 2X No
the Ma 28a-f s notifie	Director	MD Princ 10e. Street and Number	10g. Citizen of V	Vhat Cou						
3a or	Ö	4607 22nd Ave	2		USA					
"natural", or items 23a or 28a-f show edical Examiner must be notified at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No	lispanic Origin? an, Mexican, Pu Specify:	Specify Yes or No erto Rican, etc.)	14. Rac Blac Specify	k, White,	ack
Medica	Completed by	15. Decede (Specify only high: Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or 5+)	(Giv life.		during most of w d)		16b. Kind of Bu		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygientment of Health and Mental Hygientment of them 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examionce.		Elementary/Secondary (0-12) College (1-4or 5+)								ores, Inc.
more, Marylan. Pages 1 and 2 should be entr of Health and Mental in: If item 27 is marked or y or other traumatic every		17. Father's Name (First, Middle, Last) Jessie Douglas Houston, Sr. 18. Mother's Name (First, Middle, Maiden Elsie Hanley								
altimore, Maryland mit. Pages 1 and 2 should be f avernent of Health and Mental I bortant: If item 27 is marked of i nijury or other traumatic eve		19a. Informant's Name/Relation Geraldine Hous			ling Address (Street 7 22nd Av			er, City or Town,	State, Zip	Code)
f item 2		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation	2	Ob. Place of Disp cemetery, cr	Rainier, position (Name of ematory or other place	MD. 207	Date	20c. Location -	City or To	own, State
Baltimol permit. Pages Department of Important: If i any injury or once.		4 Donation 5 Dother (Specify)		oln Cemete			Brentwoo	d, M	Id.
Depa Impo any i		21. Signature of Pulleral Service	Mishall		Marshall Marshall 4217 9thS				ton, D.C. 20011	
Physician /Medical		23a. Part Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	or complications that caused the stonly one cause on each line. Metastatic	Lung C	-	ng, such as card	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death 6 Months
aminer	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Tobacco Ab Due to (or as a cor Due to (or as a cor C	ouse nsequence of):			7.4.			
physician and s the burial-transit		,	d.	naequence ory.						
y the attending phiche for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pi 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc; □ Other (specify) _	ý			e of deliv	ery Day Year
been signed by the should be detache	by	Part II. Other significant condit	tions contributing to death but no	t resulting in the	underlying cause giv	en in Part I.				the cause of death?
2 33	Completed						24a. Was auto perfi 1∐ Yes	ormed?	death?	opsy findings available ompletion of cause of
artific ctor,	Be (25. Was case referred to medic examiner?				26. Place of D	eath (Check only	one)		
ttending Physician: The Jeath. ttor: After this certificate he the funeral director, page	ို	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?								fy)
within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could	tigation	At home, farm, s		Yes 2 □ No	28f. Location ((Street and Numb own, State)	er or Run	al Route Number,
4 nours a Funeral I tely filled	ledical Ce	29a. Certifier (Check only (Ch								
within 2 To the I	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year									Day, Year)
En	30. Name and address of person who completed cause of death (Item 2 a) (Type, Print)									
(10)		John E. McKni	ght, MD 1150 V	Varnum S	t. NE #10	8 Wash	ington, I	OC 20017		
Sta Registr		31. Date filed (Month, Day, Yea AUG 0 6 200)	32. Registrar's	Signature	Ţ.					

DHMH 17 Rev 1/2001

Kevin Dennis Huskey

Dennis Hu		1- For State Registrar		ent of Health and Mental Hy ate of Death	Reg. No.	14. 2.35
Physicia al Exami			uskey		2. Date of Death Month Day Year August 6, 2007	3. Time of Death 0839 hrs
		Facility Name (if not Institution, give street and number) St. Joseph Medical Center		4b. City, Town, or Location of Death Towson	4c. County of E Baltimore	County
Funeral Director		578-82-2844 1XM 2 F	e (In yrs. last birt 44	hday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	-	I. Birthplace (State or oreign Wash. DC Country)
daryland 28a-f show any 1 at ouce.	tor	D.C.	10c. City, Town Was	hington	10g. Citizen of What	10d. Inside City Limits 1 X Yes 2 No
death with the Maryland or items 23a or 28a-f sho nust be notified at once	Dire	10e. Street and Number 4428 Falls Terrace S	.E.#1	10f. Zip Code 20019	U.S.A.	•
fter death wi	by Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year or Date:	Ever in U.S.	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto Yes 2 X No specify:		
uld be filed within 72 hours a Mental Hygiene. marked other than "natura c event, the Medical Ex m	Completed b	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5	(+)	Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use reti Counselor		
be fi	å	17. Father's Name (First, Middle, Last) Hearndon Huskey 19a. Informant's Name/Relationship (Type, Print)	[40]	18. Mother's Name		hie
mit. Pages I and 2 should partment of Health and M. portant: If item 27 is ms jury or other traumatic	То.	Shelly Jones - Fiance	20h Place	069 Plaza Circle,	Joppa MD 2108	5 tv or Town, State
permit. Pages I Department of F Important: If injury or other	11-	1 X Burial 2 Cremation 3 Removal from Sta 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Fort	ory or other place) Lincoln Cem. Aug 22. Name and Address of Facility	1.11,07 Brentw	ood,MD
a a ∃ ∃ nysician Medical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.		A production of the contract o		Approximate Interval Between Onset and Death
kaminer	. 15	Immediate Cause (Final disease or condition resulting in death) a. <u>NYPET CERSTV</u> Due to (or as a consessed and the conditions)			,	
rted J ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		.*		
te be executed tysician and burial - transit	Nedical	X UNPENDED #23a.PTI 2		872, 10/16/07TT	23d. Date of de	livery
e death certificate be the attending physici ed for use as the buri		23b. Was decedent pregnant in the past 12 months?	time of death	Fetal death 3 Ectopic pregna Other (Specify)		Day Year
ires that the signed by the		Part II. Other significant conditions contributing to death Myocardial tunnel, 4 cm	but not resultin	g in the underlying cause given in Part I.	23e. Did tobacco use contribu	
cian: The law requir certificate has been s ector, page 2 should	Completed by				autopsy prio performed? dea	re autopsy findings available for to completion of cause of the? Yes 2 No
ding Physi After this funeral dir	To Be	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Inju (Month, Day,Y)	nt 2 V ER/O ry 28b.	26.Place of Death (Check utpatient 3 DOA Other4 Nursin Time of Injury 28c. Injury at Work? 1 Yes 2 No		Other:
or A fter Direc	Certification:	Suicide Could not be determined (Specify)		arm, street, factory, office building, etc.	28f. Location (Street and Number or Town, State)	
To the Hospital or within 24 hours afte To the Funeral Dis completely filled in	edical	Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examiner and manner stated.		ath occurred at the time, date and place, and nvestigation, in my opinion, death occurred a 29c. License number	at the time, date and place, and due	
		Ometz	n (h- 00)	O.C.M.E.	August 7, 20	
ļ		 Name and address of person who completed cause of d Ana Rubio MD. Assistant Medical Exam 		Penn Street, Baltimore, MD 2120	1	

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

	Pleas	e Type or	Print in B	lack Ind	delible In	k. Ensu	re All Cop	ies A	re Legible	
_		State o	f Marvland	d / Depa	artment of	Health a	and Mental	Hvai	ene	
1 - State Registrar		_	,	_	tificate o			, ,	g. No. 2 (11)	7 2669
1. Decedent's Name	e (First, Middle,	Last)						of Death		3. Time of Death
Miriam				Huds	on		Augu		L, 2007 Yea	4:13 A M
4a. Facility Name (//	f not institution,	give street and nu	nber)		4b. City, Town	, or Location o	of Death		4c. County of De	eath
Shady Gr	ove Adv	entist H	ospital		Rockv	ille			Montgom	ery
5. Social Security N 174-16-		6. Sex 1 □ M 2 💢 F	7. Age (In yrs. la 86	ast birthday) Yrs.	If Under 1 Ye Months Day		Min. 8. Date Min. Feb	of Birth th, Day 2 7	^{year)} , 1921 Per	Birthplace (State or Foreign Country) nnsylvania
Usual Residence of										
10a. State	10b. County		10c. City	, Town or Lo						10d. Inside City Limits
Md.	Monto	gomery		ŀ	Rockvi	lle				1. Yes 2 □ No
10e. Street and Nur	mber		,		10f. Zip Cod			10	g. Citizen of What	Country?
9701 V	eirs I	rive			20	350			USA	
11. Marital Status		12. Was Dec	edent Ever in U.S	3. 13. V	Vas Decedent	f Hispanic Ori	gin? (Specify Yes i, Puerto Rican, et	or No-		merican Indian,
1 Never Marri	ied 2 ☐ Marrie	d 1 ☐ Yes	2√ No				i, Fuerto Ficari, et	(C.)	Black, W	
3 Widowed	4 Divorced	If Yes, Gi Year or D		1	I□Yes 2√□I	o Specify:			Specify: W1	iice
(Spec	15. Decedent's	Education grade completed)		(Give	lent's Usual Oc kind of work do	ne durina mos	t of working	1	6b. Kind of Busines	ss/Industry
Elementary/Seco	ndary (0-12)	College (l-4or 5+)		OO NOT use ret	,			3.79	
12		l		ног	nemake				AT Hor	ne
17. Father's Name	`_ `	,					er's Name (First, M		aiden Surname)	
Ralp	h Spec	ck				Al	lida Sp	eck		
19a. Informant's Na	ame/Relationshi	p (Type. Print)		19b. Mailin	g Address (Stre	et and Numbe	er or Rural Route	Number,	City or Town, State	e, Zip Code)
Pam Ungu	ris -	Daughte	er	9405	5 Fait	n La.,	, Damas	cus	, Maryla	and 20872

Important: If it any injury or o once. **Physician** /Medical

attending pl

page

After this

after death | Director: / d in by the f

within 24 hours a To the Funeral I

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

other than "natu

Director

Funeral

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Completed

Be P

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

disease or condition resulting in death) Examiner The law requires that the death certificate be executed physician and sthe burial-trans

Physician/Medical

þ

Completed

Be

ပ္

Certification:

Medical

Sequentially list conditions, if arry, leading to infriediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23a. Part1. Enter the disease, or shock, or heart failure. List

Immediate Cause (Final

20a. Method of Disposition

1 ☐ Burial 2X Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

> lication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause in each line. Respiratory Failure Due to (or as a consequence of)

Chronic Obstructive Pulmonary Disease

20b. Place of Disposition (Name of cemetery, crematory or other p

Due to (or as a consequence or)

Congestive Heart Failure Due to (or as a consequence of):

Diabetes Mellitus Uncontrolled

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2X No

9 Unknown

23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 4□Pregnant at time of death

5 ☐ Other (specify) 9∏Unknown

3 ☐ Ectopic pregnancy

place)

Hysong Co., Inc.

22. Name and Address of Facility

23d. Date of delivery Month Dav Year

23e. Did tobacco use contribute to the cause of death?

20c. Location - City or Town, State

2222-Wisconsin Ave., NW

Washington, DC

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Kidney Disease StageIII

Gram Positive Septicemia

24a. Was an autopsy perform

Date

Metropolitan Crematory-8/3/07-Alexandria, Va.

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of

1□ Yes 2X No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 ☐Other (Specify)

,	death? 1 ☐ Yes	2□ No	

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

5 Pending investigation 6 Could not be determined

Hospital: 1 Anpatient 28a. Date of Injury (Month, Day Year) Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

3□ DOA

2 ER/Outpatient

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

KC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Fisehatsion Mehari,

0064478

29c. License number

1,2007

29d. Date signed (Month. Day, Year)

ess of rerson who completed cause of death (Item 23a) (Type, Print)

M.D.

9901 Medical Center Dr., Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year AUG 0 6 200)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 2007ear July 31, 12:35 PM Hugh Edward Hartman, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Dec. 18) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months 1153 M 2 □ F 1933 Dec. 73 160-26-9768 Pennsylvania Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Exaπiner must be notified at 1 No 2 No Director Maryland Frederick Walkersville 10g. Citizen of What Country? 10e. Street and Number 8382 Curiosity Court 21793 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 XYes 2 No1953-If Yes, Give Year or Dates: 1975 1 Never Married 2 Married White 1 ☐ Yes 2XX No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced ss 1 and 2 should be filed within 72 houn of Health and Mental Hygiene. Item 27 is marked other than "natural other traumatic event, the Medical E. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Non-Commissioned Officer U.S. Air Force 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Irene Marshall Hugh Edward Hartman, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8382 Curiosity Court, Walkersville, MD 21793 Renee' B. Hartman / Wife t: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 6, 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☆Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 2007 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory Frederick, Maryland 21. Signature of Linear d Servic L censee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the dis Immediate ause (Findisease or condition resulting in death) Pulmonary Fibrosis **Physician** years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Pulmonary Hypertension Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Diabetes 24a. Was an 2 X No Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 🔯 Inpatient 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending Injury n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral filled in the funera 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Registrar

2007

James Cockrell

29b. Signature and title of certifier

7901 Maple Ave. Takoma Park, MD 20912

ess of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

July 31, 2007

16x1

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State AUG 1 5 2007 Registrar

29b. Signature and title of certifier

Brian Avin, M.D

2730 University Blvd, West, #410, Wheaton, MD 20902 32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D20696

29d. Date signed (Month, Day, Year)

August 14, 2007

			State of f		artment of Health and M rtificate of Death		iene 0 1 7	26701
			1. Decedent's Name (First, Middle, Last)			2. Date of Deat Month	Day Year	3. Time of Death
	Physicia /Medic	-	Mamie L. Jones			Ju1y	27, 2007	2:46 A M
	Examin	_	4a. Facility Name (If not institution, give street and number	ar)	4b. City, Town, or Location of Death		4c. County of Death	
			2020 Brooks Drive Apt. 61		District Height:		Prince Ge	
	Funeral		1 M 2 ME	Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Cou	place (State or Foreign intry)
h	Director		577-38-7689	77 Yrs.		July 15	, 1930 Sout	th Carolina
	end #		10a State 10h County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mary	ŏ	Maryland Prince George's	District	Heights			1 🔀 Yes 2 🗌 No
	the 28a	rec	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What Cou	intry?
	3e or	<u> </u>	2020 Brooks Drive Apt. 61	2	20747		United Stat	AC
	me 2	Funeral Director	11 Marital Status 12. Was Decede		Was Decedent of Hispanic Origin? (Split Yes, specify Cuban, Mexican, Puenc		14. Race - Amer	ican Indian.
و	or Ite	Ē	Armed Force 1 Never Married 2 Married 1 Yes 2 If Yes, Give	YNO	1 ☐ Yes 2 ☐ No Specify:	rnican, etc./		ffican-
8	ral',	d b	3 ☐ Widowed 4 ☑ Divorced Year or Date	s:	TE 183 ZEA NO OPOUNY.		Specify: Ame	
2	72 h	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ting	16b. Kind of Business/l	ndustry
2	Athin hen.	шþ	Elementary/Secondary (0-12) College (1-4	or 5+)				
,	filed within 72 hours after death with the Marylend Hygiene. sther then "natural", or Iteme 23e or 28e-f ehow ant, the Medical Examinar must be notified at		12 years 17. Father's Name (First, Middle, Last)	Resi	dent Manager	e (Firşt, Middle, M	<u>Government</u> Maiden Sumame)	
Maryland 21215-0036	ntal hed od od od	Be	Thomas C. Wharton			ie Bass	n n	
2	should and Me mark matk	ဍ	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Number or Ru		; City or Town, State, Z	ip Code)
S	th ar th ar 27 is 1 trau		Vanessa M. Jones - Daught	er 2020	Brooks Dr. #612	District	Heights, M	D 20747
ē,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylen Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow any Injury or other traumatic event, the Modical Examinat must be notified at once.		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place)	Date	20c. Location - City or 1	Town, State
Baltimore,	Pege ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	16		4, 2007	Landover,	MD
Ħ	mit. Sertm Sorte		21. Sign, ture of Funeral Service Licent Ph		2. Name and Address of Facility St			
ä	99 6 8	l l	bhny Wu	and the	4001 Benning Road	NE Wash	nington, DC	20019
п			23a. Part Enter the disease, or complications that cau shock of heart failure. List only one cause on eac	sed the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Pnysician	i 5			eatic Cancer			Onset and Death
	/Medical		resulting in death)	as a consequence of):				
	Examiner		Sequentially list conditions. b.					
	D is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of):				
	and I-tran	хаш	that initiated events c.	as a consequence of):				
760,	The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	ical E						
687	icate phys	edic	d.				1	
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Division of Vital	for Attendent efter deat Director: I in by the	Certification:	4 Homicide determined building	, etc. (Specify)	reat, tactory, office	City or Town		
	To the Hospital or Attentwith 24 hours effer death To the Funeral Director: completely filled in by the				th occurred at the time, date and place			
	the Ho hin 24 h the Fu mpletely	Medical	(Check only one) 2 Medical Examinar: On the bas and manne		nvestigation, in my opinion, death occu	rred at the time, d	late and place, and due	to the cause(s)
	To the within To the comple	ž	29b. Signature and title of certifier		29c. License number	2	29d. Date signed (Monti	h, Day, Year)
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0	(5)		30. Name and address of person who completed cause	1	Print)	1 1	nn A. Thon	
			122/ Mercantile La 31. Date filed (Month, Day, Year) 32. Reg	ne Lare	10, MD 2077	t Ly	AN 4. INON	195
	Sta Registi		AUG 0 3 2007 Sevent	distrar's Signature	•			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:10 P M Sheila Jackson 2007 2 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 1 F 75 578-58-8392 May 26, 1932 Ireland Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location ns 23a or 28a-f show must be notified at Brentwood 1XYes 2 No Prince Georges MD Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or items 23a or: 3609 Webster Street 20722 USA Funeral ural", or items 2 Examiner mus 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Doogan Anthony Doogan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert A. Jackson/Husband 3609 Webster Street, Brentwood, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/7/07 Silver Spring, MD Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Forest Service License 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Silver Spring, MD 2072 Munes 1211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examiner be executed that initiated events resulting in death) Last and burial-tran Box 68760 attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Day in the past 12 months? Month Year 5 ☐ Other (specify) ☐Yes 2☐No ed by the a P.0. 9∏Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 🗌 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

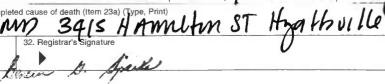
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe certificate 1□ Yes 2□ Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 [XInpatient 2M No 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 this 27. Manner of Death 1 D Natural 2 D Accident 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ∏Yes 2 ∏No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

5

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)



ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 X 109 18 7560 89 Director Sept 12, 1917 Massachusetts Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 X No Director MD Columbia Howard 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5126 Darting Bird Lane 21044 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: 3 ₩ Widowed 4 Divorced White ear or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Librarian Anne Arundel County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wallace Cassell Florence Wilcox ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Fouts/Daughter 5126 Darting Bird Lane Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Removal from State 1 ☐ Burial 2X Cremation 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 8-13-2007 Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by the detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform certificate 1∐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28h Time of Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No i Director: / death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number

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State Registrar 31. Date filed (Month, Day, Year) AUG 1 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



		1 - State Registrar Amend Item			Cen	incat	e of L	Jeath			0.	1.010
Physici	an	Decedent's Name (First, Middle, Last)							te of Death onth D	ay Yea	3. Time of Deat
/Medic		Kevin X. Mooney S			-					ust 2,2		Unknown
Examin	ier	4a. Facility Name (If not institution, give	street and number)					Location of Dea	ath		c. County of De	
		1518 Woodland Rd. 5. Social Security Number 6. Se	x 7. Aq	e (In yrs.	last birthday)	Sa. If Under	lisb 1 Year	ury If Under 24 Hi		te of Birth	Vicomic 9. E	Birthplace (State or Fore
Funeral Director			MM 2□F	74	Yrs.	Months	Days	Hours Mi	n. (Mo	onth, Day, Yea 5/1933	r)	Country)
		Usual Residence of Decedent		10.00								
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Ba-f	Director	Maryland Wicomico) 	Saı	isbury	101 7	0 1			40- 6	NA	
8 0	۵	10e. Street and Number				10f. Zip				USA	Citizen of What	Country
ns 23 marail	eral	1518 Woodland Rd.	12. Was Decedent	Ever in U.	.S. 13. W			spanic Origin?	Specify Ye			merican Indian,
Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat", or items 23s or 28s-f show any highry or other traumatic avant, the Medical Examinational Banculified at anose.	by Funeral	1 Never Married 2 Married 3 ★ Widowed 4 Divorced	Armed Forces? 1 XYes 2 If Yes, Give Year or Dates:	No	lf 1	Yes, spec □ Yes	offy Cubai	n, Mexican, Pue Specify:	rto Rican,	etc.)	Black, W Specify:	hite, etc. Vhite
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Men	2	Thomas J. Moone						Margare				
h and 7 is rr traum		19a. Informant's Name/Relationship (T)						and Number or i			or Town, State	a, Zip Code)
Healt Bm 2 ther		Kevin X. Mooney 5	r./Son	20b. P	Place of Dispos			L. IOLK	Date		Location - City	or Town, State
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ledical		resulting in death)	a Due to (or as	a conseq		,						54cars
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5 0	1 40								24	a. Was an autopsy	24b. Were	autopsy findings avai
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Medic		Cyrus	Carl	Moore				tugu	3/	3 2007	001,30 M
camin	er	4a. Facility Name (If not institution, ga)			Location of De	eath /	40	. County of Death	
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neral ector		5. Social Security Number 6. 181–16–4188	Sex 7. A 1 ☑ M 2 ☐ F	ge (In yrs. last birthdi 85 Yrs	Months		Hours M	in. (Month, D	rth a <i>y, Year)</i>	9. Birthr	
tor		Usual Residence of Decedent		85				Jun.	7,	1922	W. Virgini
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noulled at	ţō	MD Ced	cil	Elk	on						1 ☐ Yes 2 ☐ No
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	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 1	3. Was Decede	ent of Hi	ispanic Origin?	(Specify Yes or N	0-	14. Race - Americ	
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		19a. Informant's Name/Relationship								or Town, State, Zip	
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=	2: T	27. Manner of Death	28a. Date of Inju	ury 28b. Time		c. Injury Work	4 Idui Siriy	Home 5 ☐ Res 28d. Describe			home
1 LUNG	Į.	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ny Year) Injun	М		(? /es 2 □ No				
	Certification:	3 ☐ Suicide 6 ☐ Could not b	28e. Place of In	jury - At home, farm,	treet, factory,	office		28f. Location (Street an	nd Number or Rura	I Route Number,
	ert	4 Homicide determined	building, e	tc. (Specify)				City or To	wn, State)	
completely illed in by the		29a. Certifier 1 Certifying P.	hysician: To the best	of my knowledge, de	ath occurred at	t the tim	e, date and pla	ce, and due to the	cause(s)	and manner as si	tated.
	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner st	of examination and/or	nvestigation, i	in my op	pinion, death oc	curred at the time,	date and	d place, and due to	the cause(s)
	ž	29b. Signature and title of certifier			29c.	License	number		29d. Da	te signed (Month,	Day, Year)
		M Fankas	MD		Ĩ.	115	-314		4.	cust 2	2-207
		30. Name an address of person who	completed cause of	death (Item 23a) (Tvo	p, Print)	, , ,	111		Au	-941/),	-00 /
		A Farkas M	D Seec	1/	/72	11	Seil.	St. stal	F	-gust 3, Ikton,	40
Stat	te	31. Date filed (Month, Day, Year)	32. Repistr	rar's Signature	· · /)	, ,	ne leg c) · · · //e C	, -	11 1000, 1	/
egistra		AUG 6	2007 Mas	rar's Signature	Sounds!	•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August **Physician** 2007 Limas M. McIlwain 8:15 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1980 Dominoe Rd. Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth June 2 9. Birthplace (State or Foreign **Funeral** ^{Year)}923 Months Days Hours S. Carolina 1 € M 2 □ F 84 Yrs. 247-32-1779 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Maryland Anne Arundel Annapolis Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 1980 Dominoe Rd. USA death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 TYes 2 No If Yes, Give Year or Dates: 1943 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry CAFARTZ Elementary/Secondary (0-12) College (1-4or 5+) 6th 0 |Parking Attendant Manager| Parking Garage permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 Is marked other I any Injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hortense McDowell Napolean Truesdale ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M. McIlwain(Son) 273 Thelma Ave Glen Burnie, Md. 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8-8-07 Maryland Veteran Crownsville, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses ProName Reddere of CaciliSons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 MOOY83 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) USTA Physician 1cars /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed inding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes ۵ completely filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Vital Records, P.O. Box 68760 Hospital or Attending Physician: Division after death within 24 hours a To the Funeral I

State

29a. Certifier

29b. Signature and title of certifier

anine

, MI) earine werner

AUG 0 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 Bestgak Road # 300, Amapolis, MD 2140/

August 2, 2007

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) 32. Redistrar's Signature '

weine, mi)

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

DS2730

			State of Maryland / Departm 1 - State Amend #19a Per INF C871 9/19/07 JH Certific	ent of H ate of L	ealth and M D <i>eath</i>		giene Reg. No.		26707
			1. Decedent's Name (First, Middle, Last)			2. Date of Dea	ath Day	Year	3. Time of Death
£.	Physicia /Medic		JEFFERSON ISAAC MIDKIFF		_	August	<u>5, 20</u>	07	5:15 A M
	Examin	-		oity, Town, or Burel	Location of Death			4c. County of Death Prince George	
10/4	Funeral Director		5. Social Security Number 213-58-9753	ths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Aphonth, 29	, 19 52	9. Birth Cou Mary	place (State or Foreign ntry) 11and
	w w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	<u> </u>					10d. Inside City Limits
	Maryla f sho	tor	Maryland Prince George Beltsville						1 □ Yes 2 No
	r 28a	irec		. Zip Code			10g. Citizer	n of What Cou	ntry?
	th with	al D	11427 Rosedale La.	2070	05		U.S.	Α.	
	r dea	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was D If Yes,	ecedent of Hi specify Cuba	spanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No Rican, etc.)	. 14	. Race - Ameri Black, White,	
36	s afte		1 XNever Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Yes 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	es 2∭X No	Specify:		SI	oecify: Wh	ite
8	flied within 72 hours after death with the Maryland Hygione. After than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed by	15 Decedent's Education 16a Decedent's	Usual Occupa	ation	da a	16b. Kind	of Business/Ir	
212	thin 7% an "na an "Medi	ple	Flementary/Secondary (0-12) College (1-40r 5+) _	t work done o T use retired	during most of work ()	ang	0		
7	ed wit ygien ner tha t, the	Con	Laborer		18. Mother's Nam	a /First Middle		truction	o n
Maryland 21215-0036	ntal H ed oth	Be	17. Father's Name (<i>First, Middle, Last)</i> Cecil Glenn Midkiff		Georgia			iberry	
2	thould nd Me mark matic	ပ္	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Add	ress (Street a	and Number or Rui	ral Route Numb	er, City or T	own, State, Zi	p Code)
∑	nd 2 salth an 27 is r trau		linda lovee ('lem / Deventer	oolidge	e Dr. Mec	hanicsv	ille,	Md. 20	0659
J.e.	ss 1 a of Hez		20a. Method of Disposition 20b. Place of Disposition	(Name of or other place		Date	20c. Loca	tion - City or T	own, State
<u><u>E</u></u>	Page ment o		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) George Wash	ington	Cem Aug.	7,2007	Ade	lphi, l	Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licenson Donal 22. Nam Donal 4400	e and Addres Id V• I	Borgwardt r Mill Ro	Funera	1 Hom	e, PA	0705
r			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Congestive Heart Fa	ilure				155	Onset and Death 1 week
	/Medical Examiner		resulting in death) Due to (or as a consequence of):						
	LXammer	-	Sequentially list conditions, a grown leading to the large to (or as a consequence of).						
	uted insit	Examiner	Sequentially list conditions, if any, leading to unmediate cause. Enter Underlying Cause (Disease or injury that initiated events C.						
90,	icate be executed physician and s the burial-transit	I Exa	resulting in death) Last C. Due to (or as a consequence of):						
8760,	icate t physic	dical	d						
X 6	certifi nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy				23	d. Date of deliv	very
. Box	that the death certified by the attending of detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Ves 2 ☐ No 1 ☐ Ves 2 ☐ No	<u> </u>			Month Day Year		
P.0.	at the by th	hys	9 Unknown			an- Did	-1		the cause of death?
ds,	The law requires that the death certifi tte has been signed by the attending I vage 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause giv	en in Part I.				bably 4 Unknown
COL	w requ been shoul	Completed				24a. Was	an	24b. Were aut	opsy findings available
Be	The law	duc				auto perfo 1□ Yes	psy ormed? 2 No	prior to c death? 1 ☐ Yes	ompletion of cause of 2 ☐ No
ţa	(0 1	Be Co	25. Was case referred to medical		26. Place of Dea		-	1 🗀 1 63	20110
>	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Oth	er: 4⊈XNursing H	ome 5□Resi	dence 6	□Other (Spec	eify)
Division or Vital Records,	Ing Ph Viter th uneral	:uo	27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury	28c. Injur Wor		28d. Describe	how injury	occurred	
Sio	Atterding r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be 289 Place of injury - 4t home farm street fa		Yes 2 ☐ No	28f Location /	Street and	Number or Ru	ral Route Number,
증	or Ail	Certification:	4 Homicide determined building, etc. (Specify)	totory, office		City or To		realiser or ria	arriode Hambor,
	To the Hospitallor Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 125 Certifying Physician: To the best of my knowledge, death occur.						
	the Ho	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investig and manner stated.			ineu at the time			
	To t To t	Ž	29b. Signature and title of certifier	29c, Licens				signed (Month	
Δ	72)		M. J	D002	4/21		Augus	st 6, 2	007
K	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	rel.	Md 20708				
	Sta	it <u>e</u>	Sved A. Sedig 14333 Laurel Bowie Rd. Laurel Boule Rd. Laurel Rd. Laurel Rd. Laurel Boule Rd. Laurel Boule Rd. Laurel Boule Rd. Laurel	,					
		ar	I AUC OR ZUU/ K. N. A. Kieski						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2,2007 McCov. AUGUST Ruth Lois 4:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner La Plata
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 15,1926 Civista Medical Center Charles Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 1 E Washington,DC 578-38-0527 80 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla popartment of Health and Mental Hygient all when the hours are them 23a or 28a-f show Important: I flem 27 is marked other than "natural", or flems 23a or 28a-f show any injun: or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Silver Hill Director Prince George Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3907 Bexlev Pl. LISA 20746 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ౘ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Never Married 2 Married -015 MCC07 altimore, Maryland 21215-0036 1 ☐ Yes 2 Ñ No White Specify. Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Peoples Drug Store Cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Franklin Casse11 Cash Oliver, Sr. Hazel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kenneth W. McCoy/Son 7380 Bensville Rd. Waldorf, Md. 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/06/2007 Wash. National Cemetery Suitland, Maryland 5 ☐ Other (Specify) Funeral Service Licensee 21. Signatur 22. Name and Address of Facility Geo. P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Physician Months /Medical Due to (or as a consequence of) Examiner Years arterial diseave COLONALY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CKD. Parkinson's 2 No 1 Tes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No 1□ Yes Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 ☐ Kpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R. Sindlewant August and, 2007 D61614 Pembrook Sq Suite 304 Waldorf MD 20603 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Date filed (Month, Day, Yea AUG 0 6 2007

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Physician Month Joan McCullough Aug. 1, 11:00AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Months | Days | Hours | Min. | (Month, Day, Year)

Mar. | 0, 1947 Cecil 24 Willow Court 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2 🛣 F 60 172-38-0091 Yrs Director Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits r than "natural", or Itams 23s or 28e-f show the Medical Examination routilised at 1 ☐ Yes 2 🛣 No MD Cecil Elkton Direct 10e, Street and Number 10f Zin Code 10g. Citizen of What Country? 24 Willow Court 21921 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ρ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 State Gov. Counselor permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other any injury or other treumatic event RRS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Joseph Tomosky 2 Margaret Mary McCauley 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Willow Court, Elkton, MD 21921 Charles F. McCullogh 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Arlington Cemetery 8/8/07 Drexe HIll, PA 21. Signature of Fu egal Service License 22. Name and Address of Facility CC0442 eeson Funeral Home of Newark 000 2053 Pulaski Highway Approximate Interval Between Onset and Death Newark, DE 19702 -23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lige. Immediate Cause (Final disease or condition resulting in death) Physician Peripheral Vascular Disease /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, in your cause immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Cardiac Arrest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes XXNo or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 XNatural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a
To the Funeral I
completely filled peliil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier H0062851 0 Mu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bonni Roberts, 361 DO Fairhill Drive, Elkton, MD 21921 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State AUG 6 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 8:35 P M August 2 Georgia A. McEnroe 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin Nursing & Rehab. Center Berlin If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/29/1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ xF NY 81 Director 117-18-3579 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f she important; if item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified once. 1 ☐ Yes 2x No Director Ocean Pines MD Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21811 USA 10 Leslie Mews Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Sales Clerk Drug Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Chester Moore Anna Phillips 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia Hughes / daughter 25 Stacy Ct., Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 8/3/2007 4 □ Donation 5 □ Other (Specify) Cape Henlopen Crem. Frankford, DE 21. Signature of Faneral Service Ligense 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Purt1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Was autopsy performed 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending investigation

requires that the death certificate be executed Box 68760. P.0. Division or Vital Records,

as the burial-trai attending physician nse Por the detached signed by the page 2 should certificate has funeral director, After this Hospital or Attending I within 24 hours after death To the Funeral Director: filled in by completely

28a-f show

Baltimore, Maryland 21215-0036

McEnroe, Georgia

721

1 and 2 should be filed within

Pages 1

BA 8

State Registrar

Medical

6 Could not be determined

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 267

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Microscopic Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

completed cause of death (Item 23a) (Type, Print Farace 31. Date filed (Month, Day,

Year) AUG 0 3 2007

Registrar's Signature

		1 - For State Registrar	State of Ma	arylan		artmen <i>rtificat</i>			d Mental Hy		001	2.5 / 1 1
	1 199	1. Decedent's Name (First, Middle, Last) 2. Date of Death										3. Time of Death
Physicia		Goldie Simmons McGrady							08	Day	AOOT	2:30 PM
/Medic Examin		4a. Facility Name (If not institution, give					4b. City, Town, or Location of Death				ounty of Death	0, 00
		Lorien at Bel AIR Bel Air Harford									arford	
Funeral		5. Social Security Number 6. S	□M 2IXTE		ast birthday) Yrs.	If Under Months	1 Year Days	Hours M	lin. 8. Date of B (Month, D June 2	irth ay, Year)	Cour	lace (State or Foreign
Director		214–18–1757 Usual Residence of Decedent	8	16	TTS.				June 2	20, 19	21 West	Virginia
yland		10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City Limits
DIE death with the Maryland ms 23s or 28s-f show trrust be notified at	ctor	Maryland Harfor	đ	1	Aberde	en						XXYes 2□No
17 th 18 18 18 18 18 18 18 18 18 18 18 18 18	Director	10e. Street and Number				10f. Zip	Code			10g. Citize	on of What Cour	itry?
ath w	rai	300 West BelAir					21001				USA	
ltems Items	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces?			Was Deced If Yes, spec	dent of His cify Cuban	panic Origin? , Mexican, Pu	(Specify Yes or Nierto Rican, etc.)	0- 14	. Race - Americ Black, White,	
3010) -0036 hours after death w turel; or items 23a	р	3√ Widowed 4 Divorced	If Yes, Give Year or Dates:	••		1 🗆 Yes	3€ N0	Specify:		S	pecify: Whi	te
72 ho	Completed	15. Decedent's Ec	fucation		16a. Dece	dent's Usua	al Occupat	ion uring most of a	working		of Business/Inc	
2121 od within giene.	npie	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT us	se retired)		WOIKING			
1 21 lied w tygier nt, m		17. Father's Name (First, Middle, Last)	0		Real	Esta			Name (First, Middle		al Esta	te
Maryland 2121: Maryland 2121: d 2 should be filed within th and Mental Hygiene. 27 is marked other than " traumatic event, the Men) Be	Maynard J. Simm						Lola		s, maiueri S	imame)	
Should Mark	P P	19a. Informant's Name/Relationship (19b. Mailie	ng Address	(Street ar		Rural Route Numi	per. City or	Гоwп. State. Zip	Code)
MCGRAD lattimore, Marylan spartment of Health and Menta sportment of Health and Menta sportment: if Item 27 is marked in y Injury or other traumatic ev tea.		Joan M. Goodson	(daughter)		1				301, Timo			
Ore, and Head		20a. Method of Disposition		20b. P	lace of Dispo emetery, crea	sition (Nan	ne of		Date		ition - City or To	
Page ury out it		K Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other <i>(Specif</i>)		1		-			3/13/2007	BelA	ir, Mary	yland
MCGRADY GOIFE Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "naturel", or Items 23e or 28s-1 show only injury or other traumatic event, the Medical Examinet must be notified at once.		21. Signature of Funeral Service Licen	see	sh		Name an	ng-Ca	argo Fu	meral Ho nd 21001-	mc P	.A.	
		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	dications that dused	the death								Approximate Interval Between
Physician		Immediate Cause (Final disease or condition			TIA	EA	11 5	TAGE	=			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a consequ	ience of):		00	77,0-				
		Sequentially list conditions,	b									
Si ted	nfne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ience oi):							
18760, cate be executed physician and it the buriat-transit	Examine	that initiated events resulting in death) Last	Due to (or as	a consequ	ience of):							
(18760 cate be physicial the bur	dical	(d.									
	Medi	IF FEMALE:										
Records, P.O. Box 6 The law requires that the death certific ste has been signed by the attending p age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	23c. If yes, outcome 1☐Live birth 4☐ Pregnant at 9☐ Unknown	2 Fetal	death 3[Ectopic pr Other (sp				23	d. Date of delive Month	ny Day Year
P.O. hat the d	Phy	9 Unknown										
cords, P.O. *requires that the do been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death bi	ut not resu	Ilting in the u	nderlying c	ause giver	in Part I.		Yes 2		e cause of death? ably 4 Unknown
Division of Vital Records, for Attending Physician: The law requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be contact.	Completed									opsy ormed?	prior to cor death?	psy findings available inpletion of cause of
ita.	0	25. Was case referred to medical						26. Place of E	1 ☐ Yes	2X No	1 🗆 Yes	2LJ N0
on of Vital Reding Physician: The Parter this certificate har funeral director, page	ToB	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatie		ER/Outpatier	t 3 DO	Other		g Home 5 ☐ Res		Other (Specif)	′)
On C ding P J. After t	ino in	27. Manner of Death 1. ■ Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury		8c. Injury a Work?		28d. Describe	how injury	occurred	
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		iry - At ho	me, farm, str	eet, factory		es 2 No	28f. Location City or To	(Street and i	Number or Rura	l Route Number,
Divi		and Could a state of the										
Hosi 24 ho Fune	edicai	29a. Certifier 1 Certifying Ph	ysician: To the best of liner: On the basis of and manner sta	examinat	viedge, deati ion and/or in	occurred a vestigation,	at the time in my opir	, date and pla nion, death oc	ace, and due to the courred at the time	cause(s) a date and p	nd manner as st ace, and due to	ated. the cause(s)
o the	Mec	29b. Signature and title of certifier	and manner sta	iou.		290	License I	number		29d. Date	signed (Month,	Day, Year)
- 5 - 0		> Midle	asfam 1	4D			74.	5344			08/2	
4	-	30. Name and address of person who	-		23а) (Туре,		010	-17		00/	03/2	

DHMH 17 Rev 1/2001

Registrar

SURESH DHANDANI MY, 6225. UNION AVE, HAVRE DE GRACE, MD 20178

31. Date filed (Month, Day Grand) 9 200 92. Registrates Signature & Johnson

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician:

24 hours a within 24 hor To the Fune completely fi

> State Registrar

DHMH 17 Rev 1/2001

Medical

AUG 0 3 2007

Rosalyn Juergensmo 31. Date filed (Month, Day, Year)

1650 Orleans Street Johns Hopkins CRBI-186

and manner stated.

Menous

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D60203

29d. Date signed (Month, Day, Year)

2007

Baltimore Mary land

21231

29a. Certifier

(Check only one)

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene

Physician	
/Medical	
Evaminer	

Funeral

Director

death with the Maryland ages 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hyglene.

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examiner must be notified at

Baltimore, Maryland 21215-0036 Completed by 12 Homemaker permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy, Important: If item 27 is marked other any Injury or other traumatic axem 17. Father's Name (First, Middle, Last) Be Whitman Nathan Zwicker 2 19a. Informant's Name/Relationship (Type. Print) Harold Noel (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 8/6/2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Immediate Cause (Final **Physician** disease or condition resulting in death) trien /Medical Due to (or as a consequence of) **Examiner** corona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy deficien Lucinaki 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ٩ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28h Time of 28a Date of Injury 28c. Injury at Certification: After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a

To the Funeral I 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) D 39522 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Hospital Rd., Suite 310, Prince Frederick, MD 20678 Fears, MD Jonathan K. 31. Date filed (Month, Day, Year) 32. Registra Signature State 2007 AUG Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2007 12:30 A.M August 4, Alice Marie Noel 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert 421 Epworth Court, Box 519 Solomons If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 □ M 2√2 F Massachusetts 87 020-12-1966 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Solomons MD Calvert 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20688 United States 421 Epworth, Court Box 519 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 18. Mother's Name (First, Middle, Malden Surname) Elizabeth Frances McGinty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 421 Epworth Court, Box 519, Solomons, Maryland 20688 20c. Location - City or Town, State Alexandria, Virginia Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

Month

Year

performed' 1∐ Yes 2 TNo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

August 6, 2007

			1 - For State Registrar	State of Maryla		artmen e <i>rtificat</i>			and M		giene Reg. No.	07	25714		
	Dhysisi	20	1. Decedent's Name (First, Middle, Last					ath Day	Day Year 3. Time of Death						
	Physici /Medic		Virginia N						August	Bay 2	2007	18:30 PM			
1	Examir	er	4a. Facility Name (If not institution, give	,				Location o	of Death			4c. County of Death			
			Washington County 5. Social Security Number 6. Se		last hirthda		gerst	OWN	24 Hrs	8. Date of Birtl		ningto			
	Funeral Director			DM 21XF 85		Months		Hours	Min.	Jan. 4,	1922	9. Birth	olace (State or Foreign htry)		
	D		Usual Residence of Decedent						1	, ,	1,22				
	arylar	Ļ	10a. State 10b. County		City, Town or	Location						1	10d. Inside City Limits		
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	with t	Funeral Director	1 2567 Donnyshand	Desires		10f. Zip		,			10g. Citizen o		ntry?		
	eath	erai	13567 Donnybrook	12. Was Decedent Ever in	US 13		21742		gin? (Spe	cify Yes or No-	USA 14 Ba	ace - Americ	can Indian		
' O	riten Iner d	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	0.0.	If Yes, spe	cify Cubai	n, Mexican	, Puerto	Rican, etc.)		ack, White,			
ဇ္တ	rel', o	þ	3 Nidowed 4 Divorced	If Yes, Give 22 Year or Dates:		1 🗆 Yes	2 X) No	Specify:			Spec	ity: Wh	nite		
5-0	be filed within 72 hours after death with the Maryland tal Hygiene. Ad other then "natural", or items 23e or 28e-f show other then "natural", i'm Madical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)		edent's Usua e kind of wo			t of workii	na	16b. Kind of	Business/In	dustry		
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au	ld be ental ked o	To Be	Marvin Eugene Se	a]			1			ay Wolfe					
ary	shou ind M i mar umat	F	19a. Informant's Name/Relationship (T)		19b. Ma	ling Address	(Street a			Route Numbe			Code)		
Σ	and 2 selth s n 27 to		Bobby D. Seal -	brother	P.0	. Box	465,	Char	cles	Town, V	W 254	1 4			
ore	of He of He or oth		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 ▼F	20b.	Place of Dis cemetery, cr	oosition (Nar ematory or o	me of other place	9)	D	ate	20c. Location	- City or To	own, State		
Baltimore, Maryland 21215-0036	tment tant:		4 Donation 5 Other (Specify)	Ar1						9/2007_	Arling	ton, V	JA		
Bal	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mential Hygiene. Important: If item 27 is marked other than. Insturel; or items 23 sor 28s-f show eny injury or other treumatic event, the Madical Examinar must be notified as once.		21. Signature of Funeral Service Licens	ee AA 9		22. Name ar ackles				orton Fu	neral	Home			
			23a. Part1. Enter the disease, or coprol	ications that caused the dea	, L	Harpers Ferry, WV 25425 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									
	Dhusisian		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	120	A Cod A	11	,,		or copilatory and	-		Interval Between Onset and Beath		
}	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	guence of).	1001	117						MONIT		
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	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	D. D. 10 (00 00 0 00 00 00 00 00 00 00 00 00 00											
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Box	death certifica attending ph for use as t	n/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregr							23d. D	ate of delive	arv		
Ď.	death e atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		□Ectopic pr □ Other (sp						lonth	Day Year		
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5	Physician: rthis certific ral director.	o Be	25. Was case referred to medical examiner? 1 Yes 2X No	lospital: 1 Nnpatient 2] ER/Outpatii	ent 3 DC	Othe			(Check only or		h (C (
ō	D 0	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time		8c. Injury Work	4 🗆 1401		8d. Describe h			y)		
Ö	Attending r death. ector: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Worth, Day 1 ear)	Injury	м		es 2□N	No						
Division of Vital Records,	f or Att after de Directe I in by ti	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, s	treet, factory	, office		2	8f. Location (S City or Tow	treet and Num n, State)	ber or Rura	l Route Number,		
	Hospital		29a. Certifier 1 YCertifying Phys												
	Hospita 24 hours Funarel etely filled	Medicai		sician: To the best of my kn ner. On the basis of examin and manner stated.	ation and/or	ith occurred nvestigation,	at the time , in my op	e, date and inion, deat	d place, a h occurre	nd due to the c id at the time, d	ause(s) and ri late and place	nanner as si , and due to	tated. the cause(s)		
	To the Hospital or Attending I within 24 hours after death. To the Funarel Director: After completely filled in by the funer	Me	29b. Signature and title of certifier	_/ ^		290	: License	number		2	9d. Date sign	ed (Month,	Day, Year)		
1	8		VINIGIA	1 Notice	12		000	270	45		81	10/0	7		
9	10		30. Name and address of per an who co	omplete cause of death (Ite	m 23a) (Type				. /		-5-6	, , [0			
	W		L. Dwi ht Wooster				Campu	s Rd.	, Ha	erstow	m, MD	2174	2		
	Sta Registra		AUG 1 0 200	32. Tegistrar's Sign	A. S	and of									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death Silver Spring

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Robinson

7. Age (In yrs. last birthday)

2. Date of Death

July

30 Day 2007 ear

1916

County of Death

Montgomery

10:34 P M

9. Birthplace (State or Foreign

1. Decedent's Name (First, Middle, Last)

Holy Cross Hospital

4a. Facilify Name (If not institution, give street and number)

Blair

6. Sex

Robbie

Social Security Number

Physician

/Medical

Examiner

Division or Vital Records, P.O. Box 68760

Hospital or Attending Physician: To the Hospital within 24 hours a To the Funeral C

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8-1-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21201 22 S. Greene St Zimein 31. Date filed (Month, Day, Year) 32. Registrar's Signature **ORIGINAL**

DHMH 17 Rev 1/2001

State

Registrar

29a, Certifier

0 6 2007

			For State Registrar	State of Mary		•	nent of Fi icate of		viental Hy	/gien Reg. N	000	26717
	Physici	an	1. Decedent's Name (First, Middle, La						2. Date of D Month	Da	ay Year	3. Time of Death
	/Medica		Gladys Mildred		nd	AL	City Town o	al agation of Dooth	August		3 2007	11:00 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4d. County of Death									
-2.4	Funeral		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birth	day) If	Under 1 Year	If Under 24 Hrs.	8. Date of Bi	irth	9. Birth	place (State or Foreign
	Director		226-03-1417	□M 2【XF 94	+ Yı	rs. M	onths Days	Hours Min.	(Month, D	ay, Year , 19	13 Vir	ginia
-	pug w		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town o	or Locati	on					10d. Inside City Limits
	faryla show	or	,									1 X Yes 2 No
	the N 28a-1	Director	MD Montgo 10e. Street and Number	mery	υ.		of. Zip Code			10a. C	itizen of What Cou	intry?
	3a or	iO le	14910 Spring Mea	dows Drive			20874	'			ited Stat	•
	death	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	13. Was	Decedent of H	lispanic Origin? (Span, Mexican, Puert	pecify Yes or N		14. Race - Ameri	ican Indian,
98	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show atic event, the M-dical Examiner must be notified at	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 【 No If Yes, Give			1 ☐ Yes 2X No Specify:				Black, White, etc. Specify: White	
Ö	hours tural" al Exa	d by	3 XWidowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	16a D)acadant	's Usual Occup			16h I	Kind of Business/Ir	
15	in 72 n "na"	plete	(Specify only highest gra	ade completed)		Give kind life. DO	of work done VOT use retired	during most of wor d)	king	100.1	Niliu oi business/ii	loustry
212	d with giene. rr than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Но	omem	aker				Own Hom	e
ğ	e filec al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)	•			18. Mother's Nam	ne (First, Middle	e, Maide	n Surname)	
ylaı	ould b Ment arked atic e	To E	H.H. Smith						M. Fos			
lar	2 sho		19a. Informant's Name/Relationship (Larry E. Ruhland)					and Number or Ru Meadows]				
e,	1 and Healtl em 27 ther t		20a. Method of Disposition	2	Oh Place of F	Dienoeitic	n (Nama of	:	Date .		ocation - City or T	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturaly" or items 23a or 28a-f show any Injury or other traumatic event, the M-dical Examiner must be notified at any injury or other traumatic event, the M-dical Examiner must be notified at once.		1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	detropo	cremate D L i t	ory or other plac an	Augus 200			•	
alti	mit. Fortmoortar		21. Signature of Funeral Service Lige		Cren	22. N	ry ame and Addre				1 Home,	Virginia 10 East
ä	permi Depar impor any ir		TRACOJA ST	rue)		Dee	r Park	Drive, Ga	aithers	burg	, MD 208	77
ŧ,			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do no	t enter th	ne mode of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between
الم	Physician		Immediate Cause (Final disease or condition	_a. Dement	ia							Onset and Death 2 Years
	/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of)):						
1		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cor	nsequence of)):						
1	uted	Examiner	cause. Enter Underlying Cause (Disease of Injury) that initiated events									
,	ificate be executed y physician and ss the burial-transit		resulting in death) Last	Due to (or as a co	nsequence of)):	-					
09289	ate be hysici the bu	edical		d								-
	± 0 €		IF FEMALE:	One If you cuteome of no								= = = = = = = = = = = = = = = = = = = =
Вох	leath certi attending i for use a	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pr 1 Live birth 2 4 Pregnant at time	Fetal death		opic pregnancy her (specify)	у			23d. Date of delive Month	very Day Year
0	w requires that the de been signed by the should be detached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	ordeam	3 🗆 0	ner (apeciny) _					
Ф,	s that ned b e detz	y P	Part II. Other significant conditions	contributing to death but no	t resulting in t	he under	lying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
rd	equire en sig suld b	ed b	Hypertension						1 🗆	Yes 2	2 X No 3□ Pro	bably 4 □Unknown
Division or Vital Records, P.O.	law re as be 2 sho	Completed by	Bronchial Asth	ma					24a. Was	s an opsy	24b. Were aut	opsy findings available ompletion of cause of
<u> </u>	Physician: The lav this certificate has al director, page 2 a	Con	Coronary Arter	y Disease					perf 1∐ Yes	formed? 2 X N	death? o 1 ☐ Yes	2 □ No
Ziti	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea				
o	Phys r this ral di	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	28b. Tin		28c. Injur	4 LA Nursing H	ome 5 ☐ Res 28d. Describe		6 □Other (Spec	ify)
ion	nding I ath. r: After e funer	Certification:	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Inju	ury		rk? Yes 2∐No				
<u>V</u>	or Attendafter death Director: in by the	tifica	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		At home, farm	ı, street,	factory, office		28f. Location City or To	(Street a	and Number or Rui	ral Route Number,
Ö	ital or A irs after ral Dire											
	To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Medical	29a. Certifier 1 Certifying Pl (Check only 2) Medical Example (Check only 2)	aysician: To the best of my miner: On the basis of exa and manner stated.	y knowledge, o mination and/	death oc or invest	curred at the tii igation, in my c	me, date and place opinion, death occu	e, and due to the erred at the time	e cause(e, date a	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and mariner stated.			29c. Licens	e number		29d. D	ate signed (Month	, Day, Year)
	PSP0		Lash				D28	8656		Aug	gust 6, 2	2007
	Q		30. Name and address of person who									
	V		Ravi Passi, M.D.	, 8609 Secon	d Aven	ue #	404, S	ilver Spr	ing, MI) 20	0910	
	Sta Registr		31. Date filed (Month, Day, Year)	32. legistrar's S	Signatur	4						

, and the second second	· ·	-			August	3, 200	07 3:40 P. ^M
Social Security Number 6.			4b. City, Town, o	or Location of Dea	ith	4c. County o	f Death
1	Court		Damas			Mont	gomery
239-50-2172	Sex 1□ M 2 1 7. Age (In yrs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	(Month, Day	12, Year)	9. Birthplace (State or Foreign Country) North Carolin
Usual Residence of Decedent 10a. State 10b. County	11	0c. City, Town or Lo	continu				404 1-34-05-13-3
		_					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
Maryland Montgor	nery	Da	mascus			40 000 4140	
10e. Street and Number	lount		10f. Zip Code	7.2		10g. Citizen of Wh	·
		ar in II 9 12			Specify Ven or No.		- American Indian,
Never Married 2 Married Widowed 4 XDivorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	10.			erto Rican, etc.)	Black,	White
(Specify only highest g	rade completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	oation during most of w d)	orking	16b. Kind of Bus	
Elementary/Secondary (0-12)	College (1-4or 5+)	1		-,		Own I	lome
17. Father's Name (First, Middle, Las	t) Paul 1			18. Mother's Na	ame (First, Middle,		
Paul N		HOWIE HOU	16	Me1h	a Phill	lins Rid	enhour
19a Informant's Name/Relationship		19b. Maili	ng Address (Street				·
Linda Goldberg	Daughter	1					. , ,
20a. Method of Disposition		20b. Place of Dispo			Date		tity or Town, State
				t t	11/07	(a++h	Nonth Constin
						acthews,	, North Carolina
Xua. M.	Descer	M	lolesworth	n-Willia	ms P.A.,	Funeral	Home and 20872
23a. Part1. Ther the disease, or cor	nplications that caused th						
	one cause of each line.			,	,,	,	Approximate Interval Between Onset and Death
disease or condition resulting in death)			ancer				4½ years
	Due to (or as a c	onsequence of):					
Sequentially list conditions,	b. Due to (or as a c	onsequence of):					_
cause. Enter Underlying	240 10 (0) 40 4 5	encequence en.					
that initiated events resulting in death) Last	cDue to (or as a c	onsequence of):					
	d						
IF FEMALE:	23c. If ves. outcome of	pregnancy				OOM Date	of delices.
in the past 12 months?	1 ☐ Live birth 2	Fetal death 3		у			-
1 ∐ Yes 2 LANo 9 □ Unknown	9☐Unknown	ne or death 5					
Part II. Other significant conditions	contributing to death but r	not resulting in the L	inderlying cause giv	en in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
	-	-			1□1	′es 2 1X No 3	B ☐ Probably 4 ☐ Unknown
					autop	an 24b. W	ere autopsy findings available ior to completion of cause of
							ath? ⊒Yes 2□No
25. Was case referred to medical examiner?					eath (Check only or	ne)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3□ DOA Oth	er: 4 D Nursing	Home 5X Resid	lence 6 DOther	(Specify)
27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time of Injury	of 28c. Injur Wor	ry at rk?	28d. Describe h	ow injury occurred	d
2 ☐ Accident investigation							
	28e. Place of injury building, etc. (- At home, farm, st Specify)	reet, factory, office		28f. Location (S	treet and Number	or Rural Route Number,
· -		, ,,				.,,,	
29a. Certifier 1 ☐ Certifying P 2 ☐ Medical Exa	ı miner: On the basis of ex	kamination and∕or ir	th occurred at the time to the time to the time the time to the time the time the time to the time the time to the time time time the time time the time time time the time time time the time time time the time time time time the time time time time time time time tim	me, date and pla opinion, death oc	ce, and due to the c curred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
29b. Signature and title of certifier			29c. Licens	se number	2	29d. Date signed	(Month, Day, Year)
1 & Cls	~ /		ከራናደደ	RO.		August	6. 2007
30 Namaand address of narrow with	completed source of de-t	h (Itam 22a) /Tura				1108000	J, 2007
			·	11a M	1 1 O	0050	
	11. Marital Status 1	Armed Forcess 1 Never Married 2 Married 3 Wildowed 4 Divorced 1 Yes 2 No Yes 2 Year or Dates:	11. Marital Status 1 Never Married 2 Married 1 Never M	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of If Yes, specify Cub 14. Was Give 15. Decedent's Education 15. Decedent's Usual Occur (Give kind of work done 16. Decedent's Usual Occur (Give kind of work of work 18. Decedent's Usual Occur (Give kind of work of work 18. Decedent's Usual Occur (Give kind of work of work 18. Decedent's Usual Occur (Give kind work of work 18. Decedent's Usual Occur (Give kind work of work of work 18. Decedent's Usual Occur (Give kind work of	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanis Origin? 1 1 1 1 1 1 1 1 1	11. Marrias Status 1 Newer Married 2 Married 3 New Decedient Ever in U.S. Armed Forest Clause. 3 Wide Decedent of Linganic Criging? (Specify New Purple Clause, well-completed) New Part Clause New Pa	11. Manual Status 11. Diver Married 2 Married 12. Was Decedent Ever in U.S. 11. Diver Married 2 Married 13. Divideowed 4 (Dovoroed 15. Decedent's Education (Specify only impliest grade completed) 15. Decedent's Education (Specify only impliest grade completed) 16. Decedent's Education (Specify only impliest grade completed) 17. Teither's Name (First, Middle, Last) 18. Monar's Name (First, Middle, Last) 19. Monard Name/Palationarby (Type Print) 19. Monard Name/Palationarby (Type Print) 19. Married Status 19. Monard Name/Palationarby (Type Print) 19. Married Status 19. Monard Name/Palationarby (Type Print) 19. Married Name/Palationarby (Type Print) 29. Married Name/Palationarby (Type Print) 19. Married Nam

07-06230	Please Tyne	or Print in Black I	Indelible Ink	Ensure All C	onies Are I	agible	
Wayne Thomas Rol		e of Maryland / Dep				egible.	
	1- For State Registrar		ertificate of D		, 0	Reg. No.	0 7 7571
Physician/ Medical Examiner	WAINC INDIA	as Robinson			2. Date of De Month August 1	Day Yea 3, 2007	0439 hrs
_	4a. Facility Name (if not institution, 2003 Kellmore Road	give street and number)		City, Town, or Location of Dundalk	of Death	4c. County o	of Death e County
Funeral Director	212:58.7432 1	Sex 7. Age (In yrs	· · · -	If Under 1 Year If Under Months Days Hours	Min	-50	9. Birthplace (State or Foreign Country)
and show any nice.	Usual Residence of Decedent 10a. State 10b. County MD BALTI	MORE 10c. Ci	ty, Town or Location	44K		 :	10d. Inside City Limits 1 Yes 2 No
with the Maryland is 23a or 28a-f sho e notified at once eral Director	10e. Street and Number 2003 KEILMON			0f. Zip Code 21222	1 44 7	10g. Citizen of Wh	•
or items must be	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorce	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No ed If Yes, each or Paties:	If Yes,	Decedent of Hispanic Origonal Specify Cuban, Mexican es 2 No specify:		No- 14. Race White Specify: (, ,
215-0036 be filed within 72 hours after that Hygiene. rked other than "natural", ent, the Medical Examiner Be Completed by I	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade completed) College (1-4 or 5+)	during most	Usual Occupation (Give of working life, DO NOT		16b. Kind of Bus	TORIAL
	1700 013	OBINSON			's Name (First, Middle		
MD 21 d 2 should the and Me n 27 is ma aumatic ev	19a. Informant's Name/Relationship	BROTHER	11507 BA	ddress (Street and Num		OND VA	23233
imore, Pages I an nent of Hea ant: If iten or other tra	20a. Method of Disposition 1 Burial 2 Cremation 4 Dognation 5 Other Spec	Removal from State	o. Place of Disposition crematory or other RLEAN CE	. ,	Date 8-19-07		City or Town, State
Balti permit. Departn Imports injury o	21. Signature of Furieral Service Lie		22. Nan	ne and Address of Facility Daugherty Family Fur	У		**

Fetal death

contributing to death but not resulting in the underlying cause given in Part I.

ER/Outpatient 3

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Other (Specify)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Live birth

Unknown

23c. If yes, outcome of pregnancy

Pregnant at time of death

Inpatient 2

28a. Date of Injury (Month, Day, Year)

AMENDED

g

Hospital: 1

2601 Mountain Road - Pasadena MD 21122 of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

3 Ectopic pregnancy

26.Place of Death (Check only one)

Other;

Yes 2 No

28c. Injury at Work?

29c. License number

O.C.M.E.

DOA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

24a. Was an

✔ Yes 2

or Town, State)

Nursing Home 5

autopsy

performed?

28d. Describe how injury occurred

No

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

1 ✓ Yes 2 No 3 Probably 4 Unknown

death?

Residence 6 V Other: Scene

28f. Location (Street and Number or Rural Route Number, City

August 13, 2007

29d. Date signed (Month, Day, Year)

1 🗸 Yes

Day

24b. Were autopsy findings available

prior to completion of cause of

Approximate Interval Between Onset and Death

Year

2 No

Physician /Medical Examiner

Immediate Cause (Final disease

or condition resulting in death)

cause. Enter Underlying Cause (Disease or injury that initiated

events resulting in death) Last

23b. Was decedent pregnant in the

1 Yes 2 No 9 Unknown

Part II. Other significant conditions

UNPENDED

past 12 months?

Emphysema

25. Was case referred to medical

examiner?

1 V Natural

2

3

1 🗸 Yes 27. Manner of Death

Accident

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 1

IF FEMALE:

Sequentially list conditions, if any, leading to immediate

Part I. Enter the disease, or complication failure. List only one cause on each line

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed After this

Examiner and Physician/Medical certificate has been signed by the attending physician ector, page 2 should be detached for use as the burial \$ Be 10 Certification: within 24 hours after death.

To the Funeral Director: completely filled in by the fi Medical

Completed

State

nu 30. Name and address of person who completed cause of death (Item 23a)

8

Pending

Investigation

Could not be

determined

Donna M. Vincenti, MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Registrar's Signature

ÖRIGINAL

Registrar

DHMH 17 Rev 1/2001

State Registrar 260

mo facto

Stight J. Kit.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo

25 1 CAnt

32. Signature

				State of Maryland / De State Amend Item 29c per dvr,g&	nartment of Health and N 1 09/04/07dhb ertilicale of Death	Mental Hygi ™	ene g. No. 2007	26721
		Physici		1. Decedent's Name (First, Middle, Last) Charles H. Summers		2. Date of Death August 5	Day 2007 Year	3. Time of Death 4:50A M
		/Medio Examin		4a. Facility Name (If not institution, give street and number) Homewood at Crumland Farms	4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
OSTO		Funeral Director		5. Social Security Number $6. \text{ Sex}$ 7. Age (In yrs. last birthdox $217-28-1152$ $1 \text{ M} 2 \square \text{ F}$ 92 Yrs.	Months Days Hours Min	8. Date of Birth (Month, Day, June 6.	Year) Cou	
0		anyland •how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or			123	10d. Inside City Limits
0.0		the Man 28a-feh	ector	Maryland Frederick Knoxvill				1 ☐ Yes 2 ☑ No
F		sth with the Man 23s or 28s-f et unt be notified	ai Dir	1012 Rosemont Drive	10f. Zip Code 21758	10	g. Citizen of What Cou USA	ntry?
	36	within 72 hours after deeth with the Maryland ane. then "naturel", or items 23e or 28s-f ehow is Medical Examinar must be notified.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Whit	etc.
2	5-0036	72 hour naturel	sted b	3⊠ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) (G	cedent's Usual Occupation	kına 1	6b. Kind of Business/In	
96	25	_ = _ =	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of work b. DO NOT use retired) chanic		Electric Mo	tor Repair
4	g	be filed ital Hyg id othe event,	Be	17. Father's Name (First, Middle, Last) Charles K. Summers	18. Mother's Nam	e (First, Middle, M	Maiden Sumame)	
\(\overline{\sqrt{2}}\)	Maryle	s 1 and 2 should be the Heelth and Mental item 27 is marked oother traumatic eve	₽ P		ailing Address (Street and Number or Rui		City or Town, State, Zip	Code)
10		1 and 2 Heelth (em 27 i		20a Method of Disposition 20b. Place of Dis			D 21758	own, State
8/2	Baltimore,			12☐8urial 2 ☐ Cremation 3 ☐ Removal from State cemetery, c		2007	Frederick,	MD
00.81210	Balt	permit. Page Depertment of Important: if eny injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility St 1621 Opossumtown P			
9		Physician /Medical Examiner	16	23a. Part1. Enter the disease, or comblications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate	anter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
Charles	68760,	licate be executed physicien and s the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.				
Summer	.O. Box	that the death certific ed by the ettending p detached for use as i	by Physician/Me		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliv Month	ery Day Year
	rds, P	The law requires that the site has been signed by the bage 2 should be detached.		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to t s 2 ☐ No 3 ☐ Prof	he cause of death?
sounto physicians as	Vital Record		Completed	Blabeter Sie Myllitaria	4.17	24a. Was an autopsy perform	ed? death?	opsy findings available impletion of cause of
2000		Physician: The this certificate ral director, pag	To Be	25. Was c. se referred to medical examiner? 1 Yes 2 No	Other 3	th <i>(Check only one</i> ome 5 ☐ Resider	nce 6 □Other (Speci	(v)
Myc	on of	ding Phys h. After this funeral di		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)		28d. Describe how	w injury occurred	
4	Division	Hospital or ettending 24 hours after death. Funerel Director: After tely filled in by the fune	Certification:	✓2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Str. City or Town,	eet and Number or Run State)	al Route Number,
35		To the Hospital within 24 hours a To the Funerel Completely filled	edical C	29a. Certifier (Check only one) 1	ially occurred at the time, date and place investigation, in my opinion, death occur	and due to the car rred at the time, da	une(s) and manner as ite and place, and due t	o the cause(s)
		To the within 2 To the complet	×	29b. Signature and title of certifier Assume the control of the c	29c. License number D16428	29	d. Date signed (Morth,	Day, Year)
		b		30. Name and address person to complete cause of eath flem 23a) (Type Casper Cline, 300 West Ninth Street		21701		
	at,	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 7 2007 32. Signiture 34. AUG 0 7 2007				

Johns Hester Sca				e of Maryland / D		f Healt	h and N		ygiene		2.)	7 2000
Din inin		Registrar 1. Decedent's Name	e (First Middle I		Certificate of	Deali	<u> </u>		2. Date of Dea	Reg. No.		3. Time of Death
Physician Medical Examin	-		•	Scales III					Month August 2	Day	Year	1856 hrs
		4a. Facility Name (i 8906 Simps		give street and number)		4b. City, To Clinto		ation of Death		Princ	nty of Death e Georg e	e's
Funeral		5. Social Security N		Sex 7. Age (In	yrs. last birthday)	Months		f Under 24Hrs Hours Min	7		F₩eb	thplace (State or rshington
Director	L	214-08-		CXM 2 F	3 7 Yrs	S	Days	Tiodis IVIII	3-3-	1970	Co	untry) DC
		Usual Residence of 10a. State	Decedent 10b. County	10c	. City, Town or Locat	wn or Location				10d. Inside City Limits		
	اج	Md	Prince	e George's	I	Brandywine					1XXYes 2 No	
after death with the Maryland M", or items 23a or 28a-f show Iner must be notified at once.	Director	10e. Street and Nu				10f. Zip				10g. Citizen o		ntry?
th the 23a or notifie			Chestnu	t Oak Lane		200		1- 0-1-1-0 / 0		USA		ican Indian, Black,
death wi	uneral	11. Marital Status 1 Never Marri	ed 2 X Marri	12. Was Decedent Eve ed Armed Forces?	lf Y			exican, Puerto	pecify Yes or N Rican, etc.)		Vhite, etc.	carringar, black,
timore, MD 21215-0036 1. Pages I and 2 should be filed within 72 hours after de froent of Health and Mental Hygiene, retant: If item 27 is marked other than "natural", or yor other traumatic event, the Medical Examiner man	by F.	3 Widowed	4 Divorc	1 Yes 2XX	.No	Yes 2	XXNo s	pecify:		Spec	ify: Bl	ack
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5-00 ed with tygiene other i	팅	17. Father's Name	(First, Middle, La	ist)			18.	Mother's Name	e (First, Middle,	Maiden Sum	ame)	===
be file pital H irrked over	Be		Scales						in Ha			
D 2'should and Me 7' is my latic contact.	- 1	19a. Informant's Na				_	,		Rural Route No	-		
and 2 and 2 fealth item 2 traum		20a. Method of Dis		n-Scales, W	20b. Place of Dispos	sition (Nam			Date	20c. Locat	WINE tion - City or	Md 20613 Town, State
Baltimore, permit. Pages I ar Departaonen to fi He Important: If it		1XXBurial 2	¬) _	3 Removal from State	crematory or of Resurred		1	8-1	0-200		nton	ма
Baltimo permit. Page Departorent o Important: injury or oth		4 Donation 5 21. Signature of	Other Speci ner Service Lice	"X" / / /				Facility Ta	ylor	Funera	al Ho	 me
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Physician Mci I xaminer		23a. Part I. Enter the failure. List on Immediate Cause or condition resulti	ily one cause on Final disease	merications that caused the each line. a. Multiple Gunshot V Due to (or as a conseque	Vounds	the mode o	or aying, suc	ch as cardiac d	or respiratory a	rrest, snock, c	or neart	Approximate Interval Between Onset and Death
	Jer.	Sequentially list co		b	ence of):					-		
	Examiner	cause. Enter Und. (Disease or injury	erlying Cause	c	· · · · · · · · · · · · · · · · · · ·							
V = T d		events resulting in	death) Last	Due to (or as a consequent d.	ence or):							
e executed cian and rial - transi	dica	UNPENDED		AMENDED				•				
ath c	sician/	IF FEMALE: 23b. Was decedent past 12 months	pregnant in the s?	23c. If yes, outcome of Live birth 4 Pregnant at time 9 Unknown	2 Fe	etal death other (Spec		Ectopic pregn	ancy	23d. Da Mor	ite of deliver	y Day Year
O. Bat the dat the dat the dat the date that the	Phy	Part II. Other sign	ificant condition	ns contributing to death bu	t not resulting in the	underlying	cause give	n in Part I.				the cause of death?
s, P.O. nires that the signed by d be detacl	od by											bably 4 Unknown
of Vital Records, ng Physician: The law requin Mer this certificate has been s'	Completed		_							opsy formed?		utopsy findings available completion of cause of
certifi ector,	Be	25. Was case reference examiner?	rred to medical	[Hospital:			I Ott	Death (Check			- [2	
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on o	힐	1 Natural	5 Pendin	FOUND: Day, Year)	FOUND:	,,		2 No	Subject sh			
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	ertification:	2 Accident3 Suicide4 Homicide	6 Could r	not be 28e. Place of Injury	1854 hrs - At home, farm, stre (barber shop)	eet, factory	, office build	ding, etc.	28f. Location or Town 8906 Simps	State)		ural Route Number, City
e Hosp 124 hou e Funci etely fi	ပ၂	29a. Certifier	Certifying Phys	sician: To the best of my kn	owledge, death occu	urred at the	time, date	and place, an	d due to the ca	use(s) and ma	anner as sta	ted.
To the Hos within 24 h To the Fur completely	Medical			ner:On the basis of examina and manner stated.	ation and/or investiga				at the time, da			
	2	29b. Signature and	title of certifier			290	. License n O.C.M.			- 1	signed (Mi : 3, 2007	onth, Day, Year)
		30 Name and add	ress of person	no completed cause of death	(Item 23a)		0.0				-,	
1/2 (g)		Ana RubiD		tant Medical Examine		Street, E	Baltimore	, MD 2120)1			
Sta Registr		31. Date filed (Mor	oth, Day Year)	32. Registrar's S	Signature							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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/ear	3. Time of 1917			

	Re	or State <u>listrar</u> Decedent's Name (First, Middle,La	st)	Certific	ate of Deati	<u> </u>	Reg. 2. Date of Death		3. Time of Death
Physician/		John Hask		pencer			Month D August 9, 20	007	1917 hrs
LAdillillo		. Facility Name (if not institution, gi	ve street and number)			Town, or Location of I	Death	4c. County of De St. Mary's	eath
		21847 Three Notch Road		(In yrs. last bir		er 1 Year If Under	24Hrs. 8. Date of Birth(MM/DD/YYYY) 9.	. Birthplace (State or
Funeral Director	1	Social Security Number 6. S 6. S 6. S 6. S 6. S 6. S	XM 2 F	46		s Days Hours	Min. 11/08/	Fo	Country) <u>T11inoi</u>
	U	a. State 10b. County		10c. City, Towr	or Location				10d, Inside City Limit
d how any			Mateo	Sa	n Carlos				1 Yes 2 X
the Maryland a or 28a-f shutified at once	1	e. Street and Number			10f. Zip	Code	10g	. Citizen of What	
3a or 3		3328 Brittan Ave	nue, Apt.	#4	12 Was Docad	94070	n? (Specify Yes or No-		States American Indian, Black,
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other transmate event, the Medical Examiner must be notified at once. To Be Compiled by Furneral Director	1	. Marital Status X Never Married 2 Marrie	12. Was Decedent Armed Forces?	X No	If Yes, spec	ify Cuban, Mexican,	Puerto Rican, etc.)	White, e	,
fter des	- 1		ed If Yas, Give Year			X No specify:			White ness/Industry
natural" xamine		15. Decedent's Education (Specify			 Decedent's Usua during most of wo 	Occupation (Give k orking life, DO NOT u		TBD: Killy of Busin	essimuosity
5-0036 ed within 72 hour lygiene. other than "nature Medical Exat	2	Elementary/Secondary (0-12)	College (1-4 or		oftware	Trainer		Informat	ion Technolo
d with	┋┝	7. Father's Name (First, Middle, La				1	Name (First, Middle, M		
215 be file mtal III rked o	2	David Gelvin S	Spencer		Oh Mailing Address	Jef	fry Withers ber or Rural Route Numb	Burress oer. City or Town,	State, Zip Code)
should is may atic ex	_	9a. Informant's Name/Relationship		111			Chapel Hill	. North	Carolina 10
and 2 : lealth a traum		David G. Spencer Oa. Method of Disposition		20b. Place	e of Disposition (Na latory or other place	ame of cemetery,	Date	20c. Location - C	ity or Town, State
ages 1 nt of H rt: If i	- 1	Burial 2 XCremation 4 Donation 5 Other Spec		late	sfield-Ec	hols Cr.			e Hall, MD
altin mit. Partme partme portan	+	1. Signature of Funeral Service Li	censee		22. Name ar	nd Address of Facility			Home, P.A.
m Pagaii		Kyle S. Simons 3a. Part I. Enter the disease, or co	// _M (1206	22955	Hollywood	Rd., Leona	st, shock, or hear	MD 20650-02 t Approximate Inte
sician		3a. Part I. Enter the disease, or confailure. List only one cause or	n each line. a. Alcohol and			y 1			Between Onset and Death
aminer		mmediate Cause (Final disease or condition resulting in death)	Due to (or as a con	sequence of):	OII IIICOAIC		y at		
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60, ate be exe hysician e burial -		IF FEMALE:	23c. If yes, outc	come of pregnar	су			23d. Date of o	delivery Day Year
ision of Vital Records, P.O. Box 68760, artending Physician: The law requires that the death certificate be executed retain. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit by the funeral director, page 2 should be detached for use as the burial - transit.	Physician/N	3b. Was decedent pregnant in the past 12 months?	- Louis	at time of death	2 Fetal dea 5 Other (S		c pregnancy	Montas	23,
30X death of a for ur	ysic	1 Yes 2 No 9 Unkr					220 Did t	phaces use contril	bute to the cause of death
P.O. Es that the gned by the detached	by Ph	Part II. Other significant condition	ons contributing to de	ath but not resu	Ilting in the underly	ing"cause given in P			Probably 4 V Unknown
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Vital hysicians this certi	Be (examiner?	Hospital: 1 Inpa	atient 2 E	R/Outpatient 3	DOA Other	Nursing Home 5	Residence 6	
Division of Vital Records, pital or Attending Physician: The law requirements after death. eral Director: After this certificate has been sifiled in by the funeral director, page 2 should be	ı: Το	1 ✓ Yes 2 No 27. Manner of Death	.28a. Date of (Month, Da		8b. Time of Injury	28c. Injury at Wo		how injury occurr	ed
ion Hendir Heath. Hor: A	atio	1 Natural 5 Pend 2 Accident Inves		/2007	Fnd 7:17 pr	n tory, office building,		(Street and Numb	er or Rural Route Number Three Hotels N
lor Al	ertification:	deter	not be		s in Hotel		or Town, Rm 410 I	State) 2184/ exington I	Three Hotels M Park, MD
F 2 2 F	S	4 Homicide 29a. Certifier 1 Certifying Pt			I the account of the	t the time date and t	place, and due to the cau	use(s) and manne	r as stated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Example 29b, Signature and title of certifie	and manner stat	ed.	Jonganon,	29c. License numbe	er	29d. Date sign	ned (Month, Day, Year)
	2	290. Signature and the or certifie	11 16,0	(This	nue	O.C.M.E.	OCME	August 10	, 2007
		30. Name and address of person Theodore M. King, Jr.		of death (Item 2 t Medical Ex	(3a) kaminer 111	l Penn Street, E	Baltimore, MD 2120	01	
	tate	Of Data Stad (14 ath Day Your)		strar's Signatur		<i>M</i> a			
Regis		Mills L	לחוזיר ול	رمس	9. 4				

07-06153	
Joey F. Struensee	

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State of Maryland / Department of Health and Mental Hygiene

oey L. Sildenset		1- For State Criticate of Death		2011	7 2672
Physiciar		Registrar 1. Decedent's Name (First, Middle,Last)	Date of Death Month		3. Time of Death
Medical Examin	er	Joey E. Struensee	August 10,		1757 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death St. Mary's Hospital Leonardtown		4c. County of Death St. Mary's	1
Funeral	4		8 Date of Birt	h(MM/DD/YYYY) 9. Bir	thplace (State or
Director		Months Days Hours Min	140	Foreig	
	- 1-	388-82-3434 1X M 2 F 38 Yrs. Usual Residence of Decedent	Feb. 7	, 1909	wisconsi.
any		10a. State 10b. County 10c. City, Town or Location		V-1,14.1	10d. Inside City Limits
Aaryland 28a-f show Lat once.	ا ا	Virginia King George Colonial Beach	127	11.11	1 Yes 2 X No
Maryl 28a-	Director	10e. Street and Number 10f. Zip Code	. 10	g. Citizen of What Cou	ntry?.
ih the	<u>-</u>	446 Rolando Drive 22443		United Stat	
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene team 27 is marked other than "natural", or items 23a or 28a-f shotter and Medical Examiner must be notified at once.	Funeral	11. Marital Status ' 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S		White, etc.	ican Indian, Black,
fer de		1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2X No specify:	7 : 1 . [2]	Specify: Wh	nite
ours af ntural cathin	g P	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v		16b. Kind of Business/	Industry
6 172 hc cal Es	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	rea)		
003 within giene her th	틹.	12 Labor 17. Father's Name (First, Middle, Last) 18. Mother's Name	/First Middle A	Constructi	Lon '
115-	ğ Be		Peterso:		
21215-0036 Duld be filed within 7 I Mental Hygiene I marked other than ic event, the Medica	라	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I			e, Zip Code)
MD and 2 sho alth and m 27 is aumati		Steven Struensee / Brother N 2232 Bryan Ave. Nei	.11svill		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	
Baltimore, permit Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify: Dells Dam Cemetery 8/		Levistowns	-
Balt permit Departi Import injury	ſ	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bri			
A PROPERTY OF THE PARTY OF	4	Kyle S. Simons M01206 22955 Hollywood Ro	ad Leon	ardtown, Ma	ryland 2065
Physician /Medical	ſ	failure. List only one cause on each line.	911		Between Onset and Death
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		Sequentially list conditions, b			
	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
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60, ate be ex obysician te burial	Medical	IF FEMALE: AMENDED #23a, PII, 27, perME, g870, 8/24/07 TT		23d. Date of deliver	
1876 tiffcat ing phy as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy		y Day Year
Box 687 e death certific the attending p ed for use as th	Sici	4 Pregnant at time of death 5 Other (Specify)			
D. Be t the de by the	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
P.C res that signed to be deta	2	Diabetes mellitus		2 No 3 Pro	
Division of Vital Records, P.O. and or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by the funeral director, page 2 should be detacted.	Completed		24a. Was a		utopsy findings available
e law e has l	티		autops perfor	med? death?	completion of cause of
ital Recician: The last certificate la rector, page		25. Was case referred to medical 26.Place of Death (Check		2 No 1 Y	es 2 No
Vita ysicia wis cel	9 Pe	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursin	ng Home 5	Residence 6 Othe	r:
1 Of Jing Ph After t funeral		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	now injury occurred	
Sion trend death. ctor: y the f	Certification:	1 X Natural 5 Pending 1 Yes 2 No			
Jivis al or A safter I Dire	Ĭ	3 Suicide 6 Could not be determined (Specific)	28f. Location (S or Town, St		ural Route Number, City
Di lospital t hours a uneral l		29a. Certifier 1 Continue Physician To the heat of my knowledge death accurred at the time date and class are	I due to the cause	e(s) and manner as stat	ed
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
1 × 1 × 1	ğ	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
LC NP		Mlane Brassell ML O.C.M.E.		August 12, 2007	
22	t	30. Name and address of person who completed cause of death (Item 23a)		<u> </u>	
, Lx		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
Stat Registra	te	31. Date filed (Month, Opticear) 4 ZUL 32. Registrar's Signature			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2, Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear **Physician** Trader Nellie August 6, 2007 5:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Pocomoke City Worcester 4117 Stockton Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral Months Days Hours 1 M 2 XF Yrs 226-26-5153 81 12/11/1925 North Carolina Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County - Phow r than "naturel", or iteme 23s or 28s-f ehov the Medical Examiner must be notified at 1 Yes 2 No Maryland Worcester Pocomoke City Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21851 USA 4117 Stockton Road death v Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 X Widowed 4 □ Divorced white Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) It Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) Bookkeeping Retail 12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny lighty or other traumatic event SDR. 17. Father's Name (First, Middle, Last) Be Mary Roberta Hill Charles Linus Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7276 Cherrix Rd., Snow Hill, MD 21863 Linda Timmons/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/7/07 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee Professional Association Solvent Hill Rd., Salisbury, MD 21804 ans Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death) **Physician** retroper. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burialiclan/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death ed by the a Physi 9 Unknown 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No 2 No 1 Yes Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) þ 2 1 Inpatient 2 ER/Outpatient 3 DOA his After this funeral of 27. Manger of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

BA5

Box 68760.

P.O.

Records,

Division of Vital

State Registrar 31. Date filed (Month, Day, Year) AUG 08 2007

ess of person who completed cause of death (Item 23a) (Type, Print)

Suite 206 Salistrusy, m)

State Registrar 2001 Medical Parkway. Annapolis MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2007

32. Registraris Signature

DOUGES 5 MITCHELL

JUN

31. Date filed (Month, Day, Year)

7-0621 ohn Fre	ರ ederick ೌ	Fuck	er, Jr State of Maryland / Department of Health and Men		ible.	
	ou on or		1- For State Certificate of Death	-	ı. No.	7 . 7 7 7
1	Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death
ledica	ıl Exami		John Frederick Tucker Jr.	Month August 12,	2007	1730 hrs
			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Anne Arundel Medical Center Annapolis	of Death	4c. County of Death Anne Arundel	
	Funeral			er 24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birt	hplace (State or
	Director		216-15-7278 1XXM 2 F 33 Yrs. Months Days Hours		Foreig	
			Usual Residence of Decedent			
	w any		10a. State 10b. County 10c. City, Town or Location 10m Anne Arundel Churchton			10d. Inside City Limits
1	Maryland 28a-f show d at once.	ē		[40	g. Citizen of What Cour	1 Yes 2 X No
Δ	th the Maryland 23a or 28a-f sho notified at once.	اف	10e. Street and Number 5519 Baskin St. 10f. Zip Code 20733		g. Citizen of What Cour USA	u y :
	hours after death with the Maryland 'natural', or items 23a or 28a-f sh Examiner must be notified at once		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ori-		14. Race - Ameri	can Indian, Black,
	items	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican		White, etc.	
	after d nl", or ner m	by Fu	3 Widowed 4 Divorced of Yes, Give Year of Dates:		Specify: Wh	ite
	nature (xami	8	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give during most of working life. DO NOT	kind of work done	16b. Kind of Business/I	ndustry
	in 72 han " lical E	plet	Elementary/Secondary (0-12) College (1-4 or 5+) 1 Tree Climber		Construct	ion
21215-0036	ed within 72 Tygiene. other than " the Medical	Completed	17. Father's Name (First, Middle, Last) 18.Mother	r's Name (First, Middle, M	aiden Surname)	
215	be file ntal Hy rked o	Be	John F. Tucker	cky Vierkor	n .	
21	nould is man	ျှ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nur 10hn F. Tucker Father 100 Hampton Rd. L	mber or Rural Route Num	ber, City or Town, State	, Zip Ccde) 33759
	and 2 shou lealth and N tem 27 is n traumatic		John F. Tucker Father 100 Hampton Rd. L 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	
ore,	프플트ョI		1 Burial 2 X Cremation 3 Removal from State Metro Crematory	8/17/2007	Baltimore,	
Baltimore,	t. Pag tment rtant: y or o		4 Donation 5 Other Specify:			
Bal	permit Page Department of Important; injury or oth		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12. Ridgely Ave.			, F.A.
	ysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as of	cardiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
I.	Vedical caminer	8 2	failure. List only one cause on each line. Immediate Cause (Final disease a. Drowning complicated by alcohol intoxicated)	tion		Death
-^	aimici		or condition resulting in death) Due to (or as a consequence of):		- 1	
		ᡖ	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			
4	xecuted 1 and - transit		events resulting in death) Last Due to (or as a consequence of):			
	a a	lical	XUNPENDED AMENDED 47.27,28a-f,perME,g870, 8/24/07 T	т		
.60,	icate be physical the buri	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	1	23d. Date of deliver	/
Box 68760,	eath certific attending p	ian/	past 12 months?	ic pregnancy	Month I	Day Year
3ox	death e atter for u	ysic	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown			
P.O.	that the d ned by the detached	F.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P		bacco use contribute to	
σ.	ires th signe d be de	d by	Atherosclerotic cardiovascular disease		2 No 3 Prol	
Division of Vital Records,	w requir is been s should	Completed	<u> </u>	24a. Was autop	sy prior to	topsy findings available completion of cause of
Şec	The lar	E O		perfor		es 2 No
<u> </u>	ysician: The l his certificate l director, page	Bec	evaminer?	(Check only one)		
Ξ	Physic r this al dire	일	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA		Residence 6 Othe	T:
0	ding Ph h. After t funeral		1 Natural 5 (Month, Day, Year)	, No	_	
Sio	Atter rector by th	icati	2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, e	- Bubject u	YOWNED Street and Number or Ru	ıral Route Number, City
οį	ospital or Attene hours after death meral Director: y filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) found in bay	or Town, S		rundel Cnty. M
	Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p	lace, and due to the caus	e(s) and manner as stat	ed.
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic or mpletely filled in by the funeral director, page 2 should be detached for use as the burn	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.			
	لگ	Ĕ	29b. Signature and title of certifier 29c. License number	r	29d. Date signed (Mo	
	100		Dong Wincont, M.D O.C.M.E.		August 13, 2007	
- (7		 Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltim 	nore, MD 21201		
		tate				
	ہ Regis		31. Date filed (Month, Day, Xear) 5 2007 32. Reg strar's Signature			

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland	Department	of Health	and Me	ntal Hygiene

/latthew Aaron Tw Physician	1 R	- For State Registrar 1. Decedent's Name (First, Middle,Last)	Reg		3. Time of Death
Medical Examine		Matthew Aaron Twilley 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Month August 12,	2007 4c. County of Deat	1157 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 385 Broadleaf Drive Court Severna Park Millersy		Anne Arunde	
Funeral Director		5. Social Security Number 217-04-8678 1 X M 2 F	_	(MWDD/YYYY) 9. Bi /1983 Forei	
and show any		Usual Residence of Decedent 10a. State		-	10d. Inside City Limits 1 Yes 2 X No
n the Maryland 3a or 28a-f sho	2 2	10e. Street and Number 385 Broadleaf Court 10f. Zip Code 21108	7-11	g. Citizen of What Cou US	A
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Heath and Manal Hygiene. In: If item 27 is marked other than "natural", or items 23a or 28a-f she in the item 27 is marked other than "natural", or items 23a or 28a-f she in other traumatic event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced of Divorced of Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? ('S If Yes, specify Cuban, Mexican, Puerto Topates) 14. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Topates 15. Was Decedent of Hispanic Origin? ('S If Yes, specify Cuban, Mexican, Puerto Topates)	Rican, etc.)	White, etc.	rican Indian, Black, White
11215-0036 ltd: filed within 72 hours after Aontal Hygiens and Hygiens and Hygiens event, the Medical Examines	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Works	tired) :	16b. Kind of Business Con	struction
21215-0036 Motal Hygiene Motal Hygiene r event, the Medica	e D	17. Father's Name (First, Middle, Last) Russell A. Twilley, III Gail L	e (First, Middle, Ma . Heilmar	1	1_
ore, MD 21. s 1 and 2 should be freath and Mer If item 27 is mar		19a. Informant's Name/Relationship (Type, Print) Russell A. Twilley, III/Father 19b. Mailing Address (Street and Number or Russell A. Twilley, III/Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery)	4		21108
		1 X Burial 2 Cremation 3 Removal from State Glen Haven Memorial Park 4 Donation 5 Other Specify: Au Crematory or other place) Au Glen Haven Memorial Park	ig. 17, 2007	Glen Bur	nie, MD
	1	21. Sign ture of Funeral Service Licenses 22. Name and Address of Sacility Barrance of Sons, 495 Gov. Ritchie	Hwy, Seve	erna Park,	Funeral Home MD 21146 Approximate Interval
Physician Maical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Heroin intoxication and cocaine use	or respiratory arros	st, shoot, or hour	Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	-		
red red	اش	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. C. Due to (or as a consequence of):			
60, tte be executed hysician and e burial - transit	Medical	X UNPENDED X AMENDED #4a-b.23a.27.28a-f. perME.9870.8/24/07 TT IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	erv
Ox 6876 sath certificat attending ph or use as the		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown No 9 Unknown	nancy	Month	Day Year
P.O. B es that the de igned by the be detached i	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tot		to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Completed		24a. Was a autops perform	sy prior to med? death?	
Sal R	Be C	25. Was case referred to medical examiner?	k only one)		
F Vit	인	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nurs 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		Residence 6 Oth	ner: Scene
on o	<u>=</u>	1 Natural 5 Position (Month, Day, Year)	unk	on many occamed	
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Fineral Director: After this certificate I completely tilled in by the funeral director, page	Certification:	2 Accident Investigation Investigation Suicide 6 X Could not be determined Homicide Homicide Find 8/12/2007 Find 10:45 am 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) House	or Town, St	tate)	Rural Route Number, City 1ersville, MD
To the Hosp within 24 hor To the Fane completely fi	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, are more) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause I at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
F % F 8	Me	29b. Signature and title of certifier O.C.M.E.		29d. Date signed (A August 13, 200	
	Ì	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	01		
Sta Registr	_	31. Date filed (Month, Day, Year) AUG 1 5 2007 32. Fegistrar's Signature			
DHMH 17 Rev 1/200	_	ORIGINAL	OCME	.	

			For State Registrar		artment of Health and I ertificate of Death					
þ	Dhuaia	0.0	Decedent's Name (First, Middle, Last)		Timedia or Bodin	Reg. 2. Date of Death Month	3. Time of Death			
1	Physici /Medi	cal	Barbara L.	Tilghr		August	3, 2007 2:10 A. M			
	Examir	ner	4a. Facility Name (If not institution, give street ar 2709 Tred Avon Cour	,	4b. City, Town, or Location of Death Waldorf		4c. County of Death Charles			
- ~	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ½	7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Ye. 7/21/43	9 Birthplace (State or Foreign			
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits			
	Mary a-f sho filed a	tor	Md. Charle	es Waldor	f		1 XYes 2 No			
	th with the 23a or 28a ust be not	ral Director	10e. Street and Number 2709 Tred Avon Cour	t	10f. Zip Code 20601	10g.	Citizen of What Country? U.S.A.			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married 1 If Ye	Yes 2XX No	Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes ※ No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. African- Specify: American			
2-0	72 ho 'natur dical I	eted	15. Decedent's Education (Specify only highest grade comple	16a. Dece	dent's Usual Occupation	kina 16b.	. Kind of Business/Industry			
Maryland 21215-0036	filed within Hygiene.	Completed	Elementary/Secondary (0-12) Colle 11th	ife.	e kind of work done during most of work DO NOT use retired) nemaker	C	own Home			
yland	should be fil nd Mental H i marked ott imatic even	To Be	17. Father's Name (<i>First, Middle, Last</i>) John R. Allen		Agne	e (First, Middle, Maid s Mae Jani	fer			
	and 2 sho ealth and 27 is m er traum		19a. Informant's Name/Relationship (Type. Print Velma Phillips/Daughte	er 2709	ng Address (Street and Number or Ru D Tred Avon Ct., Wa	ral Route Number, Cit ldorf , Mary	ty or Town, State, Zip Code) rland 20601			
Baltimore,	Pages 1 and of He		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal		matory or other place)	i	Location - City or Town, State			
Ħ.	it. Pa irtmen irtant: njury		4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee	Harmony M	i		ndover, Maryland			
Ba	permit. Departri Importa any Inju		Jany W.	J/200 4	2 Name and Address of Facility H.S.Washington & 1925 Burroughs Ave	.,N.E.,Was	nc. hington, D.C. 20019 Approximate Interval Between			
	Physician /Medical Examiner	Medical resulting in death) Due to (or as a consequence of):								
68760,	tificate be executed g physician and as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a consequence of): e to (or as a consequence of):	7					
P.O. Box 68	The law requires that the death certifics tie has been signed by the attending pt bage 2 should be detached for use as t	Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year			
rds, P	quires that en signed b uld be deta	by	Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to the cause of death?			
Vital Records,	ysician: The law requir is certificate has been s director, page 2 should	Completed	25. Was case referred to medical			24a. Was an autopsy performed 1 Yes 2 X	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
>	Physicia this cert al direct	To Be	examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpatier	Othory	h (Check only one)	6 □Other (Specify)			
0	ng Ph (fter th			Date of Injury 28b. Time o		28d. Describe how in				
Division or	for the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifice completely filled in by the funeral director, p	Certification:	2 Accident investigation 3 Suicide 6 Could not be	Place of injury - At home, farm, str building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)			
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: T	o the best of my knowledge, death	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause	(s) and manner as stated			
	To the H within 24 To the F complete	Medical	one) and 29b. Signature and title of certifier	manner stated.	29c, License number					
)	Z × Z		At Wei	Mn	Non GIA TO		Sate signed (Month, Day, Year)			
0	,	-	30. Name and address of person who completed	cause of death (Item 23a) (Type,	Print)	1, 5	gane, Waldorg, MD 20603			
	Cto	to	ATUL KATYM MY 31, Date filed (Month, Day, Year)	Surfe # 30 32. Registrar's Signatura	4, 11350 Jemb	worke So	ganle, Walkouf, MI)			
	Sta Registra	ar	31. Date filed (Month, Day, Year) AIIC 0 8 2007	1. Bould	V		12005			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month Richard Lynwood Tomlinson August 2007 9:06 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Director 243-56-6512 70 Feb. 6, 1937 Illinois Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at Maryland Frederick Director Frederick TXXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2389 Bear Den Road 21701 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: "natural", or it edical Examin 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be If item 27 is marked or other traumatic ev Milton ပ Lynwood Tomlinson Martha Mound 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pam McGhee/Niece 928 NC Highway 96 East, Youngsville, NC 27596 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 ☐Removal from State Stauffer Crematory 8/7/2007 Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 23a. Pa 1/3 mer ne disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock if near it failure. List of the cause on each line. Approximate Interval Between Onset and Death 7 Days Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Failure /Medical Due to (or as a consequence of): **Examiner** Psuedomonus Pneumonia 10 Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Leukopenia 10 Days the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical Chemotherapy 30 Days attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Non small cell CS Lung 1 XYes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Chronic lymphocytic leukemia 24a. Was an autopsy performed? certificate I 2∐ No 2**√**□ No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1X Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D14625 August 6, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 501 West Seventh Street, Frederick, MD 21701 P. Gregory Rausch 31. Date filed (Month, Day, egistrar's Signature 2007 AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar Amend Item 21 per fh, 8870, 28 (14.84 chib) Death	Reg. No.	17 2573
Me	Physici edical Exam			2. Date of Death Month Day Year July 30, 2007	3. Time of Death 1635 hrs
-			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of D	Death 4c. County of I	
			21631 Ringgold Road (Rt. 418) Hagerstown	Washingto	on
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 F 40 Yrs. Months Days Hours		J. Birthplace (State or Coreign California Country)
	any:	٠.,	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	À	_	Maryland Washington Hagerstown		1 X Yes 2 No
	Maryland 28a-f show d at once	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What	Country?
	h the N 3a or 3			United Sta	ates
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	Funeral		? (Specify Yes or No- ruerto Rican, etc.) 14. Race - A White, e	American Indian, Black, etc.
	rs afte ural",	by	3 Widowed 4 M Divorced if Yes, Give Year 1991 – 199/ 1 Yes 2 No specify:	Specify: W	
	nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after not Health and Mental Hygiene. it: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kin during most of working life. DO NOT us	nd of work done 16b. Kind of Busin e retired)	ness/industry
	5-0036 led within 7 Hygiene. other than	nple	2 Inventory Manager	Federal	Government
	5-00% iled withi Hygiene I other th			Name (First, Middle, Maiden Surname)	
	2121 hould be fill and Mental F is marked	Be		a Belle Crawmer	
	MD 2121 d 2 should be f Ith and Mental n 27 is marker aumatic even,	P			
	ore, MC s 1 and 2 sl of Health an If item 27		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.	Date 20c. Location - Ci	
	Baltimore, Mpermit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	ugust 7,	
	Iltin			2007 Frederical Services, Skkot	K, Maryland
	Balt permit Depart Impor injury		Reschaven Funeta	tn. Hwy. Frederick,	
	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card failure. List only one cause on each line.	diac or respiratory arrest, shock, or heart	Approximate Interval
	/Medical raminer		Immediate Cause (Final disease a. Multiple Injuries		Between Onset and Death
			or condition resulting in death) Due to (or as a consequence of):		
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
		Examiner	cause. Enter Underlying Cause (Disease or injury unactinuated		
	ecuted and - transit	Exa	events resulting in death) Last Due to (or as a consequence of):		
	ਬੂ ਫ	ical	UNPENDED X AMENDED 11 per wife g873 11-7-07 vt		
	760, icate be ex physician the burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of de	livery
		sician/		regnancy Month	Day Year
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	O. Enthe	' Phy		23e. Did tobacco use contribut	te to the cause of death?
1	P.C.	d by		1 Yes 2 No 3	Probably 4 🗸 Unknown
-	w requires I been sign should be of	Completed			re autopsy findings available in to completion of cause of
	eco he lav ate has	E G		performed? dea	
	tal Rection: The certificate ector, page	Be C	25. Was case referred to medical 26.Place of Death (Cr		103 2 10
_	of Vital Records, P.O. g Physician: The law requires that the this certificate has been signed by neral director, page 2 should be detaclored.	TO B		lursing Home 5 Residence 6 🗸 (Other: Scene
		Certification:		28d. Describe how injury occurred Subject passenger of vehic accident	cle in vehicular
	Division tal or Attendi rs after death. al Director: /	tific	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number of Town, State)	or Rural Route Number, City
	ospita hours nueral			21631 Ringgold Road (Rt. 418)	
	Divis To the Hospital or A within 24 hours after To the Futeral Direc completely filled in by	Medical	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.		
	E 8 E 8	Me			(Month, Day, Year)
ſ	U.		Thoday 11 1/ of Th. 110 O.C.M.E.	July 31, 2007	,
•	1xMx,		3". Name and address of person who completed cruse of reath (Item 23a)		
_	W'	(0)	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltin	nore, MD 21201	
	St Regist	ate trar			
_		_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2007 Month Physician Laura Frances Welty 5, Aug. 5:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth
Sept • 24, 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Min. 217-30-5967 1 □ M 2 🖫 F Hours 1906° ountry) MD 100 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examina. 10c. City, Town or Location 10a. State 10d. Inside City Limits MD Frederick Director Walkersville Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 35 Maple Ave. 21793 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **□X**Io 1 ☐ Yes 2 No Specify: Be Completed by Specify: White 3₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John L. Baker Rhoda Estella Staub ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda Stinnett (Daughter) 35 Maple Ave., Walkersville, MD 21793 20b. Place of Disposition (Name of Magneter) (Papagery or other place) 20a. Method of Disposition 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Rennaval from State 5 ☐ Other (Specify) 4 ☐ Donation Lutheran Cem. 8/9/2007 Rocky Ridge, MD Signature of Funeral Service Licenses Bonard Adbes of Thompson Funeral Home E. Main St., Middletown, MD 21769 Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one lause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) actus **Physician** ownar desease /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trai Due to (or as a consequence of) cate has been signed by the attending physician page 2 should be detached for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dement on 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an performed After this certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

(Check only

31. Date filed (Month, Day,

29b. Signature and title of certifier

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8 2007

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DHMH 17 Rev 1/2001

claire Avenue Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 Day Year 2007 INN Oi 4a. Facility Name (If not institution, give street and numbe 4c. County of Death alisbun Icomico If Under 1 Year | If Under 24 H 8. Date of Birth (Month, Day, Year 10/27/1921 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) Days Months Hours 1 XM 2 ☐ F 85 218–16–6467 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 219 Lakewood 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 **X**Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 □ No 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Navy White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist Dresser Industries 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Levin Lester Walter Ada Travers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Morris/Daughter 219 Lakewood Dr. Salisbury, Maryland 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Wicomico Memorial 4 ☐ Donation 5 ☐ Other (Specify) 8/5/07 Salisbury, Maryland 21. Signature of Funeral Service Lig 22. Name and Address of Facility Holloway Funeral Home PA 501 Snow Hill Rd. Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MAHGNANT CARCINDWA Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea: 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 □Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 ☐ Probably 4 ☐Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗽 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of D_at 1 Natural 2 \sum Accident 28a. Date of Injury 28h Time of 28c. Injury at 28d. Describe how injury occurred

Physician /Medical Examiner

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certificate be

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or Vital Records,

Division

or Attending Physician:

To the Hospital

Physician

/Medical

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

filed within 72 hours after Hygiene.

of Health and Mental Hygiene. item 27 Is marked other than

permit. Pages 1 Department of H. Important: If iter any injury or ott

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Maryland 21215-0036

Baltimore,

burial-tran

Examiner and attending physician for use as the buria use as the page 2 director Certification:

Physician/Medical Be P

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Medical

State

Registrar

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

signed by the peen has this certificate funeral After neral Director: A filled in by the fu death. within 24 hours after To the Funeral

5 Pending investigation

6 ☐ Could not be

WARKS

9ear) 0 6

determined

29c. License number

10 BOX# 1733

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Lumber Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

mp 21802

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COASTAL HOSPICA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

🎾 gistrar's Signature 200

and manner stated.

			For State Registrar	State of Mary		Certificate of		Reg.		0670
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ere . "	/Medic		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Death	1 -1-1-1-	3 2007 4c. County of Death	0.10
		4.54	Washington County 5. Social Security Number 6. S	<u>_</u>	yrs. last birth	Hagers		8. Date of Birth	Washingto	n place (State or Foreign
	Funeral Director		219-44-2975	X□M 2□F 61	Yı	Months Dave	Hours Min.	(Month, Day, Ye	ar) 1946 Mary	ntrv)
dand	ow at		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town o	or Location				10d. Inside City Limits
Man	a-f sh tified	ctor	West Virginia Berkley		Marti:	nsburg				1 XYes 2 No
atyland Z IZI3-0030 should be filed within 22 hours after death with the Marvland	Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 159 Heather Drive			10f. Zip Code 254	401	10g.	Citizen of What Cou USA	ntry?
r death	ems 2; er mus	nera	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
J.S. affe	al", or it xamin	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Vi Year or Dates:	et Nam		Specify:	, ,	Specify: Wh:	
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	d other	Be C	17. Father's Name (First, Middle, Last,)			18. Mother's Name	e (First, Middle, Maid	den Surname)	
y la	d Ment narked natic e	2	Arthur P. 19a. Informant's Name/Relationship (Sr.	Nailing Address (Street	Maggie	L.	Frank	- 0(-)
Ma and 2 s	alth an 27 Is r		Linda Webb/Wife	rype. Fility	I	Heather D		rtinsburg		
Ses 1.8	t of He If item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	inemoval irom State	b. Place of D	isposition (Name of crematory or other place	1		. Location - City or To	own, State
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hysici	this cer al direc	To B	examiner? 1 ☐ Yes 2 ☐ No			atient 3 DOA Oth	er: 4 Nursing Ho	me 5 Residence	6 □Other (Specia	ý)
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he Hos	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Exar	niner: On the basis of exam and manner stated.	nination and/	or investigation, in my o	pinion, death occurr	red at the time, date	and place, and due t	o the cause(s)
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Registrar

			For	State	of Marylan					lental Hyg	giene			
			1 - State Registrar			Cer	tificate o	of Deat	h		leg. No.	07	1 0 7	3
	Physicia /Medic		1. Decedent's Name (First, Middle Margaret Es	telle [Walker					2. Date of Dea Month August	_	2007°	3. Time of 1 12:05	
	Examin	er	4a. Facility Name (If not institution Hillhaven Assisted			Center	4b. City, Tow Adelpl		on of Death			y of Death	orge's	
	Funeral		5. Social Security Number 579~26~2568	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs.		If Under 1 Y		der 24 Hrs. s Min.	8. Date of Birtl Feb. 27	`	9. Birthp	lace (State or itry) ington	Foreign
	Director		Usual Residence of Decedent							160.27	, 1723			
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	with the a or 28a. be notif	Director	10e. Street and Number 10000 Cherry Hi	11 Road			10f. Zip Co.	_{de} 740			10g. Citizen of Uni te	What Coun		
	be filed within 72 hours after death with the Maryland ttal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral I	11. Marital Status 1 □ Never Married 2 □ Marri	Armed F	cedent Ever in U. forces? 2 X No	.S. 13. \	Vas Decedent f Yes, specify	of Hispanic Cuban, Mexi	Origin? (Spican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla	ace - Americ ack, White,		
215-0036	nours aff ural", or Il Exami	by	3X Widowed 4 ☐ Divorced	If Yes, G Year or I	iive		I□Yes 21X		ify:		Spec		ite	
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	Dhusisian		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Right Ankle Fracture w/ Complications											veen leath
	Physician /Medical Examiner		disease or condition resulting in death)		(or as a conseq		ture w/	Comp.	11cat:	ions			3montl	າຣ
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о С	requires that the death certificate be executed seen signed by the attending physician and nould be detached for use as the buriat-wansit	Physician/Me	in the past 1€ months? 1 ☐ Yes 24 No 9 ☐ Unknown		birth 2 ☐ Feta gnant at time of d nown		Ectopic pregr Other <i>(specit</i>				N	lonth	Day Y	ear
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	To the within To the comple	Me	29b. Signature and title of certifie		Ja fel	ter s	1 4 4 1 2	cense numbe		# Ho	29d. Date sign	ed (Month,	Day, Year)	
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7-06274 laxine Bowers		Please Type or Print in Black Indelible Ink. State of Maryland / Department of H 1-For State Registrar Certificate of Department	lealth and Mental Hygiene	egible. 2007 7.673
Physiciar Medical Examin	1/	1. Decedent's Name (First, Middle,Last)	ERS 2. Date of Dea Month August 14	ath 3. Time of Death 4, 2007 2300 hrs
		,	City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director		219-38-4478 1 M 2XF 65 Yrs. 1	f Under 1 Year If Under 24Hrs. 8. Date of Bi Months Days Hours Min. AUG:	irth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 10 1942 VIRGINIA
and Show any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	BALTIHORE CI	10d. Inside City Limits 1 X Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral Director	10e. Styleet and Number 10 2 4 5 1 WOOD BROOK AVENUE 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in	Of, Zip Code 2 1 2 1 7 ecedent of Hispanic Origin? (Specify Yes or No	10g. Offizen of What Country? USA. o- 14. Race - American Indian, Black,
₽ H	- 1	1 3 Widowed 4 A Divorced II Tes, Give Teal	specify Cuban, Mexican, Puerto Rican, etc.)	White, etc. Specify: BLACK
2 - 2	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Uduring most of during mo	Usual Occupation (Give kind of work done of working life. DO NOT use retired)	16b. Kind of Business/Industry
21215-0036 uld be filed within 72 Mental Hygiene. marked other than "			18.Mother's Name (First, Middle,	DHAS HOPKINS HOSP. Maiden Surname)
MD 21215-003 2 should be filed with h and Mental Hygiene 27 is marked other t	To Be	19a. Informant's Name/Relationship (Type, Print)	HELEN ddress (Street and Number or Rural Route Number of Rural Route Number or Rural Route Number of Rural Rou	Imber, City or Town, State, Zip Code)
nore, MD 2121. ages I and 2 should be fi nt of Health and Mental I it fitten 27 is marked other traumatic event,		20a. Method of Disposition 20b. Place of Disposition crematory or other processing 20b. Place of Disposition 20b. Place of Disposition crematory or other processing 20b. Place of Disposition 20b. Plac		20c. Location - City or Town, State
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2		4 Donation 5 Other Specify: METRO CK	PEMATORY 08-23-07 e and Address of Filippy S.F.P.H.H. BROWN	BALTIHORE MB JR. FUNERAL HOME
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m	node of dying, such as cardiac or respiratory as	rest, shock, or heart Approximate Interval Between Onset and
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	se	Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter triad-nying Cause c.		
ecuted and transit	Examiner			
O, s be exect sician a	edica	UNPENDED AMENDED		2004 Date of delivery
Box 68760, e death certificate be ex the attending physician ed for use as the burial	siciar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal d 4 Pregnant at time of death 5 Other	death 3 Ectopic pregnancy (Specify)	23d. Date of delivery Month Day Year
i, P.O. B ires that the de signed by the I be detached	by Phy	Dialysis	,g	tobacco use contribute to the cause of death? as 2 No 3 Probably 4 ✓ Unknown
ords	Completed			
ital Reccion: The lav	8	25. Was case referred to medical examiner?	26.Place of Death (Check only one) Other A Nursing Home 5	Residence 6 Other:
n of Vid ding Physic 1. After this funeral dir	의: 일	27 Manner of Death 28a Date of Injury 28h Time of Injury		how injury occurred
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factorized (Specify)		(Street and Number or Rural Route Number, City State)
the Hospi hin 24 hov the Foner npletely fil	Medical C		at the time, date and place, and due to the cau, in my opinion, death occurred at the time, date	use(s) and manner as stated. e and place, and due to the cause(s)
	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 20, 2007
4		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Stre	eet, Baltimore, MD 21201	

State Registrar

32 Registrar's Signature

parks.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Juliet Jackson Bragg Aug 17 2007 6:00a. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore n/a Haven Nursing Home Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 10–18–1910 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F 219-16-9444 96 ĜΑ Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State MD**Baltimore** Woodstock 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21163 Funeral 8 Deep Powder Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: African-1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify. ģ 3X Widowed 4 ☐ Divorced American 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Schools Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Henry Jackson Addie Elaine Lee ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) M. Guy Bragg/Son 8 Deep Powder Ct., Woodstock, MD 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 8-22-07 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem. Park 22. Name and Address of Facility Wile F/ H P.A. of Balto. County ture of Funeral Service Licenses 200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alberosclerotic /Medical Due to (or as a c insequence of): **Examiner** cars 25 TWE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: Attert this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ofas a consequence of): Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? 1□ Yes 2☑ No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier keem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EM 50 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Olate of Ma	-		ificate of L		ionar i i	Reg. No.	2007	2570)
's	Physici	an	1. Decedent's Name (First, Middle, Last	,					2. Date of D Month	Day		3. Time of Death
*	/Medic	al	CHARLOTTE MARY AN 4a. Facility Name (If not institution, give				4h City Town or	Location of Death	August		2007 County of Death	9:45 p M
ji T	Examin	er	Annapolitan Assis		Comm.		Annapolis				nne Aru	
2	Funeral Director		214-30-1576	x 7. Age	(In yrs. last birt	hday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D May 29	Day, Year)	Cou	place (State or Foreign intry) 1land
	Maryland f show led at	tor	Usual Residence of Decedent 10a. State 10b. County MD Howard		10c. City, Town		ation					10d. Inside City Limits 1 ☐ Yes 2X No
	with the 3a or 28a	I Director	10e. Street and Number		IIIgiii	Lanu	10f. Zip Code 20777			10g. Citi	zen of What Cou	untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hyglene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show amy fujury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	7523 Browns Brid 11. Marital Status 1 □ Never Married 2 □ Married \$C\$Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2000 If Yes, Give Year or Dates:		1	as Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	10-	14. Race - Amer Black, White Specify: Whi	, etc.
21215-0036		Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed) College (1-4or 5-		Decede (Give ki life. D	nt's Usual Occupa ind of work done of O NOT use retired	ation during most of work l)	king	16b. Ki	nd of Business/I	ndustry
21	led wit lygiene her the	Con	12th 17. Father's Name (First, Middle, Last)	Ø		Во	okkeeper	18. Mother's Nam	e (First Midd	le Maiden	Bank Surname)	
Maryland	id be fi ental H ked ot ic evel	To Be	Edward Claude Ga	vlor				Katherin			,	
ary	should be and Mental s marked o	F	19a. Informant's Name/Relationship (7		19b.	. Mailing	Address (Street a	and Number or Ru				ip Code)
	and 2 ealth a m 27 Is		Mary Jane Gaylor/	Sister-In-	Law 75	23_	Browns B	ridge Roa	ad, Hig	hland	, _{MD} 20	777
Baltimore,	Pages 1 ment of H ant: If iter ury or oth		20a. Method of Disposition 1 ⅓ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemeter	ry, crema iel (tion <i>(Name of</i> atory or other plac Cemetery	8/23/	/2007	Scac	cátion - City or 1 ggsville	, MD
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licens	00 1/	1911 03			ss of Facility Do				
r			23a. Part1. Enter the disease, or comp	lications that caused	the death. Do r			t Avenue, g, such as cardiac			20707	Approximate Interval Between
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	_	ry Arte	ry I	Disease					Onset and Death 15 years
	/Medical Examiner		resulting in death)	a.	consequence							13 years
10		Je.	Sequentially list conditions, if any, leading to immediate cause. Each Underlying	b. Due to (or as a	consequence	of):						
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	consequence	of).						
68760,	rificate be executed ng physician and as the burial-transit			.d								
	ntificating physics as the	Medi	IF FEMALE:								-	
P.O. Box	The law requires that the death cerate has been signed by the attendir bage 2 should be detached for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □Live birth 1 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death		Ectopic pregnancy Other <i>(specify)</i>	,		-	23d. Date of deli Month	very Day Year
S,	ss that gned b	by Pr	Part II. Other significant conditions of	ontributing to death bu	t not resulting ir	the und	derlying cause give	en in Part I.				the cause of death?
ord	w require been sign	ted b	Hypertension						1 [Yes 2	□ No 3 □ Pro	obably 4 Unknown
or Vital Records,		Completed	Diabetes Mell:	itus, Type	II				pe	as an topsy rformed?	prior to death?	topsy findings available completion of cause of 2 No
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2□ER/Ou	itnationt	3 DOA Oth	26. Place of Dea			6 □Other (Spec	Assisted
on or	ng ffe	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b.	Time of njury	28c. Injur Worl		28d. Describ			HIVING
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju building, etc	ry - At home, fa . (Specify)	rm, stre	et, factory, office			(Street ar Fown, State		iral Route Number,
	the Hospital or hin 24 hours afte the Funeral Dir npletely filled in	Medical C		ysician: To the best on niner: On the basis of and manner sta	examination an							
	To the within To the comp	Me	29b. Signature and title of certifier	n m	D		29c. Licens	e number		29d. Da	te signed (Monti	h, Day, Year)
١.	~		30. Name and address of person who			(Type B		5531		A	ugust 20	2007
1	0		II T.I. 066	00 0 51	- •		- 1	te_301.	Columb	bia,	MD 2104	15
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 1 20	32 Registra	r's Signature	Age	ver)		_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	for State Registrar	0.0.0	ar y ranta	-	tificate of L	leaith and iv D <i>eath</i>	-	Reg. No.	2007	7 26139	
	Physicia	an	1. Decedent's Name (First, Mide Gladys E. Branch	dle, Last)					2. Date of De Month	Day	Year		
	/Medic	-	4a. Facility Name (If not instituti	ion, give street and number)			4b. City, Town, or	Location of Death	08/10/20		County of Dea	2:45p M	
	LXaIIIII	-i	Laurel Regional H	<u> </u>			Laurel				ince Geo		
	Funeral Director		5. Social Security Number 225-24-9997	6. Sex 7. Ag	e (In yrs. las 95	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 06/15/19	th ay, <i>Year)</i> 912	9. Bi	rthplace (State or Foreign country) VA	
	yland low at		Usual Residence of Decedent 10a. State 10b. Count	ty	10c. City, 1	Town or Loc	cation					10d. Inside City Limits	
	e Man	Director		Georges	Laurel	!			_			1 □ Yes 2X No	
	with the	Dire	10e. Street and Number 10377 Scaggsville	Road			10f. Zip Code 20723				en of What C	country?	
	death rms 23	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V		ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No	USA > 1		erican Indian,	
036	should be filed within 72 hours after death with the Maryland Mentel Hygiene. marked other than "natural", or items 23a or 28a-f show matte event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Ma 3 🖔 Widowed 4 ☐ Divorce	arried 1 ☐ Yes 2 🖔			Yes 2X No	Specify:	Hican, etc.)		Black, Wh Specify: Wh		
15-0	"natu "natu edical	letec	(Specify only high	ent's Education nest grade completed)		16a. Deced (Give i	ent's Usual Occupa kind of work done of OO NOT use retired	ation during most of work l)	ing	16b. Kin	d of Business	s/Industry	
212	d withing giene.	Completed	Elementary/Secondary (0-12)) College (1-4or s			y Line Work			Rexor	n Case (Corp	
ng	e = 0 ≥ 0	Be	17. Father's Name (First, Middle	e, Last)				18. Mother's Name	e (First, Middle	, Maiden S	Surname)		
<u> </u>	2 should be n and Mental	은	Fitzgerald 19a, Informant's Name/Relation	nshin (Tyne Print)	1	19h Mailin	n Address (Street	Unknown and Number or Rur	al Route Numb	ner City or	Town State	Zin Code)	
<u>8</u>	and 2 s ealth an n 27 Is i		Lacy Branch, Jr.	Son				Cheverly,		ior, ony or	rown, otate,	Zip Odde)	
Baltimore, Maryland 21215-0036	of H of H r iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	n 3 □Removal from State	l _		sition (Name of natory or other plac n Cemetery	e) 08/15	Date /2007		ation - City o	r Town, State	
<u>a</u>	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service	ce Licensee			. Name and Addres	ss of Facility Home, INC					
11 11	40 E 8 8		23a Part 1 Prior the disease	or complications that caused	t the death	176	01 Sandy Sp	oring Road.	Laurel.	MD 207	707	Approximate	
	Physician	Sheck, or heart failure. List only one cause of each line. Immediate Cause (Final Preumonia											
	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequer	nce of):						-	
	Examiner	-	Sequentially list conditions,	b. Sepsis	a conseque	nce of):							
7	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cates on July that initiated events	\$									
68760,	tificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as	to (or as a consequence of):								
		Wedical	IF FEMALE:										
P.O. Box	The law requires that the death certi ate has been signed by the attending page 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal de	eath 3	Ectopic pregnancy Other <i>(specify)</i>	1		20	3d. Date of de Month	elivery Day Year	
٠ <u>,</u>	res that the de signed by the a be detached t	y Ph	Part II. Other significant condi	itions contributing to death b	out not resulting	ng in the un	derlying cause give	en in Part I.	23e. Did	tobacco us	e contribute	to the cause of death?	
Örg	w require been sig should b	ted b	Enterococcus Feca	lis Urinary Trac	t Infec	tion			1 🗆	Yes 2[X	No 3□F	Probably 4 Unknown	
Records,	he law r s has be ige 2 sh	Completed by	Dehydration						24a. Was auto perfe		death?	autopsy findings available completion of cause of	
_		Be Co	Acute Renal Failu 25. Was case referred to medic					26. Place of Deat			1 ∐ Ye	s 2 No	
	hysic this ce	To E	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 📉 Inpatio		 	t 3□DOA Othe	4 LI Nursing Ho				ecify)	
Division or	Attending Physician: r death. ector: After this certifici by the funeral director,	ation:	Z I Modderitt	stigation		8b. Time of Injury	28c. Injun Work M 1 □	y at k? Yes 2 □ No	28d. Describe	how injury	occurred		
DIX	tal or Attend s after death al Director: / ed in by the f	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	-mined 200, Flace Of III)	ury - At home tc. (Specify)	e, farm, stre	eet, factory, office			(Street and wn, State)	Number or F	Rural Route Number,	
	To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by	edical		ying Physician: To the best al Examiner: On the basis of and manner st	of examination								
	To t To t	Σ	29b. Signature and title of certif	fier		m	29c. License D00649				1 1	nth, Day, Year)	
,	n		30. Name and address of person	on who completed cause of o	leath (Item 2					8	1000	/	
	+		Chike Onwuka /	7300 Van Dusen	Road, L	aurel,	•						
	Sta Registr	_	31. Date filed (Month, Day, Yea	9. 1 2007 2008	rar's Signatur	E A	partie						

		•	For State Registrar	,	Cei	rtificate of	Death		Reg. No	200	7 2571
	- H. F.		1. Decedent's Name (First, Middle, Las	st)				2. Date of De Month	ath Da	ayYear	3. Time of Death
l a	Physici: /Medic		Ethel Rea Barnes					August	16	, 2007	1:00 A. M
	Examin	- 1	4a. Facility Name (If not institution, give	e street and number)			r Location of Death			County of Deatl	
			Stella Maris	7 4 //	- l 6 binsh do. 1	'L'1.	monium If Under 24 Hrs.	O Data of Bir		Baltimor	
l	Funeral Director		5. Social Security Number 6. S 219-07-2331 1 Usual Residence of Decedent	ex 7. Age (In yr. Bge (In yr.	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da May 09	ıy, Year) Coi	nplace (State or Foreign untry) stead, MD.
	land ow		10a. State 10b. County	10c. C	City, Town or Lo	ocation					10d. Inside City Limits
	Mary Fred s	to	Maryland Baltimor	e County	Timoniu	ım					1 ☐ Yes 2 No
	h the	Funeral Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	untry?
	th wit	a	109 Hollowbrook R	load		2	1093		U	nited St	ates
	r dea	ne	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No o Rican, etc.))-	14. Race - Amer Black, White	
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	1 ☐ Never Married 2점 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2⊠ No	Specify:				hite
5	ges 1 and 2 should be filed within 72 ho t of Health and Mental Hygiene. If item 27 is marked other than "natu or other traumatic event, the Medical	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	dent's Usual Occup hind of work done DO NOT use retire	oation during most of wor	king	16b. I	Kind of Business/I	ndustry
121	within ane. than	du	Elementary/Secondary (0-12)	College (1-4or 5+) 4	ine.	Home				Own H	Iome
d 21	filed with Hygiene. Ither thai		17. Father's Name (First, Middle, Last)		<u>.</u>	1101110	18. Mother's Nan	ne (First, Middle,	, Maide		ione -
an	should be filed withir nd Mental Hygiene. marked other than matic event, the M	To Be	Elmer Rea Richa	ards			Ethel	Brumme	1		
Maryland	2 should be f and Mental H is marked ot aumatic ever	F	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Numb	er, City	or Town, State, Z	(ip Code)
	1 and 2 Health a em 27 is xther trai		Clarence L. Bar	rnes(Hus.)	109	Hollowb	rook Ro	ad Ti	mon	ium,MD.	21093
J.	ges 1 au t of Hea If item or othe	- 1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	i	. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce) Aug	Date 18,	20c. l	ocation - City or	Town, State
ij	Pages ment of I ant: If ite ury or o		4 Donation 5 Other (Specif	y) W		U.M.C.C	em. 2	007	На	mpstead	d.M.
Baltimore,	permit. Pag Department Important: I any Injury o once,		21. Signature of Funeral Service Licen	gav, A.	P	2. Name and Address eaceful 2325 Yo	ess of Facility Alterna rk Rd.	atives Timoni	Fu	neral&C	remation
1			23a. Parl 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	ath. Do not en	ter the mode of de	g, such as cardiac	or respiratory a	vest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· Ch	rome	- G.E.	002/	12	112		Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	equence of):	350/50	18500				
	Examine	_	Sequentially list conditions,	b. Due to lor as a conse							
J	led Isit	nju	cause. Enter Underlying Cause (Disease or injury	Due to for as a conse	aquence org.						
	al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a conse	equence of):						
68760,	rtificate be executed ng physician and as the burial-transit			- d							
89	ifficate g phy as the	Medical		u,							
O. Box	law requires that the death cer as been signed by the attendin 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ✓ o 9 ☐ Unknown	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у			23d. Date of del Month	ivery Day Year
P.0	that t ed by detac		Part II. Other significant conditions of			mordying causé giv	en in Part I.	23e. Did 1	tobacco	use contribute to	the cause of death?
ds	uires 1 sign Id be	d by	Conjes/	Les Man		4005		1 🗆	Yes	2 No 3 Pr	obably 4 onknown
20	aw rec s beer	Completed						24a. Was		24b. Were au	topsy findings available
Be	The la	m o			-			auto perfo 1∐ Yes	psy ormed? 250		completion of cause of 2 ☐ No
ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Dea			7,5103	2010
r >	Physician: r this certific ral director,	To E	examiner? 1 ☐ Yes 2 2 0	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Oth	ner: Alursing H	ome 5 ☐ Resi	idence	6 □Other (Spe	cify)
Division or Vital Records,	ding Physician: The lav h. After this certificate has funeral director, page 2		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Inju Wo	ry at rk?	28d. Describe	how inj	ury occurred	
Sio	Attending r death. ector: After y the funer	catic	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
Ξ	after dan after dan Direct	Certification:	4 Homicide determined	28e. Place of injury - At building, etc. (Spe	home, farm, st cify)	reet, factory, office		28f. Location (City or To			ıral Route Number,
	pital ours a eral [29a. Certifier - DertifyIng D	fysician: To the best of my k	nowledge deal	th occurred at the t	ime date and place	and due to the	- Called	s) and manner as	stated
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Example)	niner: On the basis of exami and manner stated.	ination and/or in	nvestigation, in my	opinion, death occu	irred at the time	, date a	nd place, and due	to the cause(s)
	To the within to the comp	Me	29b. Signature and title of certifier	Chode	NE	29c. Licen	se number	4		ate signed (Mont	
	5		30. Name and address of person who $EDDIE\ NAKHUDA$,		00 DULA	NEY VALLE	EY ROAD	TIMO	NIUM	1 MD 2	1093
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 1	32. Figistrar's Sig	gnature	best					

1:00 A.M.

AUGUST 16, 2007

BARNES, ETHEL

07-06391 David Brown ure All Copies Are Legible.

Please	Type or Print in Black Indelible Ink. Ensure All Copies Are L	-66
, icase	State of Maryland / Department of Health and Mental Hygiene	
1	Certificate of Death	Re

	Da	For State gistrar		Certifica	ile of Death		2. Date of Death	J	3. Time of Death	
hysiciar		Decedent's Name (First, Middl				1	Month Day August 18, 20	y Year	0549 hrs	
Examin	er	David			Brown	r Location of Death		4c. County of Death		
	48	a. Facility Name (if not institution	on, give street and number)	4b. City, Town, or Temple Hill		4 45 10	Prince Georg		
		Interstate 495 near St					le Date of Birth/M	_		
Funeral	5	Social Security Number	6. Sex 7. A	ge (In yrs. last birth	nday) If Under 1 Yea		- 7/26/1970	M/DD/YYYY) 9. Bi	gn puntry) N.Y.	
Director		116-60-3022	1X M 2 F	37	Yrs. Months Day	is riours with	7 6 197	0 0	ountry) 11.1.	
	ļ.,	sual Residence of Decedent	,42						10d. Inside City Limits	
N. W. C. W. C.	The state of the state of	0a. State 10b. County	1	10c. City, Town	or Location					
*	- '	N.Y.		Nov	York City				1 X Yes 2 No	
and f sho	5			IVEW	10f. Zip Code		10g.	Citizen of What Co	untry?	
Aaryl 28a-	Director	0e. Street and Number			1					
outh the Maryland 4,23a or 28a-f show s 5 notified at once.	히	845 Riverside			100	32		USA 14 Race - Ame	erican Indian, Black,	
with the rs 23a ne noti	ē	1. Marital Status	12. Was Decede Armed Force	nt Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	White, etc.	5 .	
eath iten	Funeral	A	Married 1 Yes	2 X No				Specify: Blac	ı.	
rer d		3 Widowed 4 D	Divorced If Yes, Give Year		1 Yes 2 X N		144	6b. Kind of Busines		
1215-0036 d be filed within 72 hours after fontal Hygiene. larked other than "natural", event, the Medical Examine	<u>\$</u>	15. Decedent's Education (Sp	pecify only highest grade c	ompleted) 16a.	Decedent's Usual Occup during most of working li	ation (Give kind of v fe. DO NOT use ret		JD. Killa of Basiles		
"na"	Completed	Elementary/Secondary (0-12	2) College (1-4 o	or 5+)		,		M 1		
36 nin 7 than dica	힐	llth grade	NA		Sales Rep	•		Macy's		
With grene	5	17. Father's Name (First, Middl	le, Last)			18.Mother's Name	e (First, Middle, Mai	den Surname)		
H Hy	اه	Raymond		Outlaw		Patric	ia	Brow	n	
21215-0036 Midble filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho ic eyent, the Medical Examiner must be notified at once.	8	19a. Informant's Name/Relatio	enship (Type, Print)	1. 19	b. Mailing Address (Str	reet and Number or	Rural Route Number	er, City or Town, Sta	ate, Zip Code):	
D shou shou and h	-	Annette Outl		other	114-116 W.	109 St	St Apt	4-B, NY.	of Town, State 025	
MD and 2 sho safth and 2 is raumat		20a Method of Disposition		20b. Place	of Disposition (Name of	cemetery,	Date	20c. Location - City	or lown, State	
S 1 a s 1 a		1 X Burial 2 Cremati	ion 3 Removal from	State	atory or other place)		-25-07	Fairlaw	m NT T	
Page lent c	- 1	4 Donation 5 Other	Specify:	Fai	rlawn Cem.				Dr. N. I.	
altimore, mit. Pages 1 at partment of He portant: If ite	Ī	21. Signature of Funeral Servi	ice Licensee				March F.H		21202	
Baltimore, MD 21 permit: Pages 1 and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ex		Brand My	Man		1101 E.	North Ave	or respiratory arres	nore, Ma	Approximate Interval	
ıysician		23a. Part I. Enter the disease, failure. List only one cau	, or complications that cau	sed the death. Do	not enter the mode of dy	ng, such as cardiac	or respiratory arres	,	Between Onset and Death	
/Medical	l		Maritina Injur	ies						
Examiner		Immediate Cause (Final disea or condition resulting in death		onsequence of):						
	1	O	b							
	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	onsequence of):						
	nin	cause. Enter Underlying Cau (Disease or injury that initiate	ed C. Due to (or as a c	of:						
- =	Examiner	events resulting in death) La	ist Due to (or as a c	onsequence or).						
executed an and al - transi	ᄪ		d							
e exe	양	UNPENDED	X AMENBEB,	14, perFH, C	870, 8/21/07 T	Т		23d. Date of del	livery	
O. Box 68760, that the death certificate be executed the attending physician and deatched for use as the burial - transit	n/Medical	IF FEMALE:	23c. If yes, or	utcome of pregnan	- 1 1 1 - 4b	3 Ectopic preg	nancv	Month	Day Year	
187 rtific ring F	an/	23b. Was decedent pregnant past 12 months?	in the 1 Live bir	th int at time of death	2 Fetal death		,,			
X 6 th cel ttend	<u>i</u>				5 Other (Specify)			T		
Box 68 e death certi the attendin ed for use a	Physicia				Iting in the underlying car	use given in Part I.	23e. Did to	bacco use contribu	te to the cause of death?	
at the	<u>a</u>	Part II. Other significant co	inditions contributing to	death but not resu	ning in the andonying or	J	1 Yes	2 🗸 No 3	Probably 4 Unknown	
P.O. es that the signed by be detac	<u>\$</u>						24a. Was a	an 24b. We	re autopsy findings available	
ds, equir een s	ļ š	-					autop	sy pric	or to completion of cause of	
aw r has b	Completed						perfor 1 ✓ Yes		ath? Yes 2 No	
Zec The cate		i			26	Place of Death (Che				
an: an:	Be					Other:		Residence 6	Other: Scene	
Vit. ysici his c	To E	1 ✓ Yes 2 No			· · · · · · · · · · · · · · · · · · ·	c. Injury at Work?	28d Describe	how injury occurred		
of of g Ph g Ph			28a. Date (Month, Aug 18,	of Injury 2 Day, Year) 2	8b. Time of Injury 28c 0539 hrs	Yes 2 V No	Driver of au	to involved in o	collision	
Parith Pa	בַּ	1 Natural 5	rending						Dural Bouta Number Cit	
SiC Atte		2 Accident	Investigation 28e. Place	e of Injury - At hom	ne, farm, street, factory, o	ffice building, etc.			or Rural Route Number, Cit	
Division of Vital Records, ria or Attending Physician: The law requirers after death. In Director: After this certificate has been since it is broader after the change of the change o	Certification:	3 Suicide 6	Could not be determined (Specify)	Interstate/E>	press		Interstate 495	near St. Barnab	oas Road, Temple Hills,	
Spitz hours nera	ع	4 Homicide 29a. Certifier	ing Physician: To the bes	at of my knowledge	death occurred at the time	me, date and place,	and due to the cau	se(s) and manner a	as stated.	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin To the Funeral Director: After this certificate has been signed by the attendin To the Funeral Director and After the funeral director nane 2 should be detached for use as	Modical	(Check only one) 2 Medica	ing Physician: To the bes	of examination and	l/or investigation, in my o	pinion, death occurr	red at the time, date	and place, and du	e to the cause(s)	
S within	i	?	and mariner s	stated.		License number		29d. Date signer	d (Month, Day, Year)	
FSE	° §	29b. Signature and title of o	pertitier /	1//		O.C.M.E.		August 18, 2	2007	
	1		1 N/4 /	1		J. J. IVI. L.				
3		30. Name and address of	erson who completed cau	se of death (Item 2	?3a)		2 04004			
9		Jack Titus MD.	Deputy Chief Medi	cal Examiner	111 Penn Street	, Baltimore, MD	J 21201			
	Stat		Year) and 3 R	egistrar's Signatur	-1-4-					
	44.0 (6.0)	31. Date filed (Month Coa)	(1 7 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	we St	CARAS D					
1 (5)	istra	THE THE RESERVE TO BE A	TOO!	CHILD NO.				OCM	r	

				State of Maryland / Department of Health and State State Registrer Certificate of Death	Mental Hy		2007	25742
		7.0		Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of D	Reg. No.		3. Time of Death
1	П	Physici		Naomi Rose Bothe	Month 08	Day 16		2:15 ^{A M}
	10.0	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De			County of Death	
8		L Admin		Manokin Manor Princess Anne		AAA AA	Somerset	t
3		Funeral	iletar.	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H Months Days Hours Mi	n. (Month, E	ay, Year)	9. Birth Cou	place (State or Foreign ntry) MD
16-200-		Director		213–18–3234 86 Yrs.	11-1	5-192	0	MD
4	.112	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
ω		Marylan f show	ō	MD Worcester Ocean City				1X Yes 2 □ No
4		ith the M or 28a-f	rec	10e. Street and Number 10f. Zip Code		10g. Citiz	zen of What Cou	ntry?
ले		3a or	i D	109 Ocean Drive 21842			U.S.A.	
0)		72 hours after death with the Maryland 'naturel', or Items 23e or 28a-f show digal Exertitut must be indiffed at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur	(Specify Yes or Nerto Rican, etc.)	10-	14. Race - Ameri Black, White	can Indian,
3	9	after or Ite	/Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No 1 □ Yes 2 ★ No Specify:			Specify: Wh	
CTS	5-0036	72 hours natural',	d by	3 X Widowed 4 ∐ Divorced Year or Dates:				
9	15		jete	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wife. DO NOT use retired)	vorking	10D. KII	nd of Business/Ir	idustry
2	2121	filed within 7 Hygiene. other then "sent, the Mer	E C	Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker		0	wn Home	
岩	d	e filed Il Hygi other vent, I	Be Completed		lame (First, Midd	le, Maiden	Sumame)	
2	<u> a</u>	should be ind Mental I	To B	Henry Squires Sue	Squires			
مع	Maryland			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Num	ber, City o	r Town, State, Zi	p Code)
5		is 1 and 2 of Health (item 27 is other tra	1	Mr. Ron Bothe / Son 300 Bullens Road		e, TN		
Ö	ore			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place)	Date		cation - City or T	
Naomi Bothe	altimore,	2 7 9 9			-21-2007	_	n Burnie	
_	Ba	Departm Departm Importa any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 Second Ave SW	Singleton Glen			ne, P.A. 21061
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	iac or respiratory	arrest,		Approximate Interval Between Onset and Death
		Physician		Immediate Cause (Final disease or condition DEMENTIA				YEARS
		/Medical Examiner		resulting in death) Due to (or as a consequence of):				
	<i>></i> -1.	The second second	-K	Sequentially list conditions, Tany, leading to inmediate Due to [or as a consequence of]:				
		nsit	Examiner	cause. Enter Underlying Cause (Disease or injury				
	Ć.	exection and items in and items in a second in a secon	Exa	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
	68760,	ificate be executed g physician and as the burial-transit	edicai	d				
	_	rtifica ng ph as th		IF FEMALE:		Ţ		
	Вох	leath certiff attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		2	23d. Date of deli-	very Day Year
		ie dez the al	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify)				,
	P.0	 requires that the defense signed by the should be detached 	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Dio	i tobacco u	ise contribute to	the cause of death?
	ds,	sign sign d be	d by		10	Yes 2	⊒ ₩0 3 □ Pro	bably 4 Unknown
	S	w req beer shou	Completed		24a. Wt	as an	24b. Were aut	opsy findings available ompletion of cause of
	Re	The larate has	E C		pe	topsy formed?	death?	ompletion of cause of 2 No
	tal	ician: Th certificate rector, pag	a)	25. Was case referred to madical 26. Place of 1	1 ☐ Yes Seath (Check only		1 103	
	₹ Vi	ysician: ils certific director,	ToB	examiner? 1 Yes 2 No Cther: Nursing	gHome 5 ☐ Re	sidence	6 ☐Other (Spec	ify)
	0	tending Ph leath. tor: After th the funeral		27. Manner of Death 1 □ Netural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describ	e how injur	y occurred	
	Sio	death. ctor: Ai y the fu	catio	2 Accident investigation M 1 Yes 2 No				
	Division of Vital Records,	2003	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or 7	(Street an own, State	id Number or Ru i)	ral Route Number,
		Hospital 4 hours a Funeral I tely filled		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	ace, and due to th	e cause(s)	and manner as	stated.
		To the Hospital or within 24 hours after To the Funeral Director Completely filled in the Funeral C	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.				
_		To the within 2 To the comple	ž	29b. Signature and title of certifier 29c. License number	/		te signed (Month	
		1		Mens - my 0806 29		811	6/200	7
_	1	d 1	l i	30. Name and address of terson who completed cause of death (Item 23a) (Type, Print) Start Ann Gurrant 1415 Sour Division 31. Date filed (Month, Day, Year) AUG 2 1 2007	and Co-	- 2	3 (mici	sury mo
		3m	_	31. Date filed (Month, Day, Year) AUG 2 1 2007 AUG 2 1 2007 AUG 2 1 2007		-		2/304
		Sta Registi		AUG 2 1 2007 Marin St. Soule				

Blankenship, Dorothy Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		For State Of Ivial yial Id. / State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	, ,	g. No 2007	25740
Physici		Dorothy Blankenship		Month	19 2/85	3. Time of Death
/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
,	M	Hranklin Square Hospital 5. Social Security Number U 6. Sex 7. Age (In yrs. last b	birthday) If Under 1 Year If Under 24 Hrs.	9 Date of Birth		more
Funeral Director		227-54-8669 Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, May 31	Year) Cor	nplace (State or Foreign intry) rginia
Maryland 1-f show fied at	tor		own or Location Essex			10d. Inside City Limits 1 ☐ Yes ※ No
th with the 23a or 28a ist be notl	Funeral Director	10e. Street and Number 9811 Langs Road	10f. Zip Code 21221	10	g. Citizen of What Col	untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. I important: I flem 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	by Funer	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates;	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
in 72 hour n "natural fedical Ex	Completed t	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 1	6b. Kind of Business/I	
ed with /giene. er thar t, the N		Elementary/Secondary (0-12) College (1-4or 5+) 12th	Leasing Agent		Realto	rs
ntal Hy ed oth event	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, M	,	
should nd Me mark matic	ည	Roy Thompson 19a. Informant's Name/Relationship (Type, Print) 19	9b. Mailing Address (Street and Number or Rui	a Diamo		in Code)
and 2 salth ar		Pamela Waltz	101 Wise Ave. Bal			,
Pages 1 ment of He ant: If Iten ury or oth		1 Tourist O Compation O Compation Court Company	tery, crematory or other place) ly Hill Cemetery 8		Oc. Location - City or T Baltimo	
permit. Departi Importi any inj once.		21. Signature of Funeral Service Licensee	Connelly Funera	1 Home	Ave. Bal of Essex	
hysician		23a. Part1. Enter the disease, or complications that caused the diath. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	o not enter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence b. Chemic	Bowe 1			
and -transit	Examiner	Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (ur as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ratory distress :	syndro	me	
trincate be executed g physician and as the burial-transit	edical E	Non-ST Ele	ratory distress s VAtion Myocardia	rction		
I ne law requires that the death certifics te has been signed by the attending pt lage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 myonths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 1 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death			23d. Date of delive	very Day Year
luires that signed by lid be detai		Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
	Completed by	Hypertensiun		24a. Was an autopsy perform	prior to c led? death?	topsy findings available ompletion of cause of
ertifica ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Deat	1 Yes 2 h (Check only one		2 140
× .2 0	은	1 ☐ Yes 2 No Hospital: 1 ☑ Inpatient 2 ☐ ER/C			nce 6 Other (Spec	ify)
naing Pnysician: The la th: T. After this certificate has e funeral director, page 2	tion	1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	b. Time of 28c, Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how	w injury occurred	
or Atternation of Att	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
n 24 hours and Funeral	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	lge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
withi To tl	Ž	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month	, Day, Year)
7		30. Name and address of person who completed cause of death (Item 23a)	(Type Print)		8/19/2	001
() Sta	te.	Dr. Mercedes Errell 9000 31. Date filed (Month, Day, Year) 32 Registrar's Signature	Franklin Square	Drive	Balto, 1	MD 21237
Registr		AUG 2 1 2007 Langue 15	Goods,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Mary A. Baker 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kosedale Himose gyare If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Date of Birth (Month, Day, **Funeral** (Month, Day, Year) Nov. 8, 1934 Days 1 □ M 2 □ XF Maryland 212-32-5955 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Funeral Director MD Baltimroe Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 30 N. Kresson Street 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2₹ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 ☐ Yeo Specify: Specify:White 2 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) item 27 is marked other than "natu other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Frieberg Charles Robinson ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara Baker /daughter 30 N. Kresson Street Baltimore MD 21224 Department of Healt Important: If item 2: any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Qurial 2 ☐ Cremation 3 ☐ Removal from State MOreland Memorial 8/18/07 Baltimore Md 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Fu A Service License 300 Mace Ave.Balto. MD Connelly Funeral Home of Essex 21221 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. 23a. Park. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Physician monia neu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or a sequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed the burial-trar and Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has perform 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes this Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No lospital or Attendii 4 hours after death. Funeral Director: A filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

27

Box 68760.

P.0.

Division or Vital Records,

State Registrar 31. Date filed (Month, Day, Year)

1 9000 Franklin Square Drive Baltimore, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

TILAK JOSH

			For State Registrar	State	e of Mar		/ Depa		t of H	lealth	and M	•		9	ne.	26745
	Physici /Medic		1. Decedent's Name (First, Middle Arup Kumar Bas									2. Date of De Month August	18,	200		3. Time of Death
	Examir	er	4a. Facility Name (If not institution Shady Grove Ad	lventist	t Hospi			Ro	ckvi.						gome	
l.	Funeral Director		5. Social Security Number 467-65-4496 Usual Residence of Decedent	6. Sex 1⊠ M 2□		59	t birthday) Yrs.	Months	1 Year Days	If Under Hours	Min	8. Date of Bi (Month, Di October	av. Year	947	9. Birthpl Coun	lace (State or Foreign try) India
Baltimore, Maryland 21215-0036	with the Maryland a or 28a-f show t be notified at	ctor	10a. State 10b. County	tgomery	1		Town or Lo		mac						11	0d. Inside City Limits 1 □Yes 2X No
	th with the 23a or 28 ist be no	al Directo	10e. Street and Number 11596 Paramus	Drive				10f. Zip	Code 0878					tizen of W ited		
	rs after deat I", or items : xaminer mu	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Marria 3 □ Widowed 4 □ Divorced	ied Arme	Decedent Eve ed Forces? Yes 2 1 No es, Give or Dates:	er in U.S.		Was Dece If Yes, spe 1 ☐ Yes		ispanic Or an, Mexica Specify		ecify Yes or No Rican, etc.)	0-	Black	c, White,	an Indian, etc. n Indian
	be filed within 72 hours after death w tral Hygiene. d other than "natural", or Items 23a event, the Medical Examiner must b	Completed	15, Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education st grade comple	eted) ege (1-4or 5+)			kind of wo DO NOT u	rk done se retired	during mo: i)	st of worki	ing	Ì		l and	Drug
	e filed Il Hygi other vent, t	e l	17. Father's Name (First, Middle, Nitai Gobind H		5+		кев	gulat	ory	18. Moth	er's Name	(First, Middle	, Maider			ration
	es 1 and 2 should be of Health and Mente item 27 is marked rother traumatic ev	-	19a. Informant's Name/Relations Mamta Gautam Ba				11596	Par	amus	Driv		al Route Numi	-			
	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S 21. Signature of Funeral Service	(pecify)	-		ce of Disponence	Cremat	orium	ı	Augu	st 21, 2007 ert A.	Bet	hesda phrey 557 W	a. Ma	wn,State aryland eral Home/ nsin Ave.
	Physician	8 1	23a. Part1. Enter the disease, or shock, or heart fallure. List Immediate Cause (Final disease or condition	complications only one cause	that caused the on each line.	e death.	Do not ent	er the mo	de of dyir	mary I	s cardiac	z v respiratory	arrest,			Approximate Interval Between Onset and Death Days
	/Medical Examiner		resulting in death)	Du Du	Due to (or as a consequence of): Cardiac Arrest Days								Days			
I Records, P.O. Box 68	ate be executed sysician and ne burial-transit	cal Examiner	Sequentially list conditions, the state of t					lypertension					Months		Months	
	at the death certificate I by the attending physi- tached for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1	es, outcome pf Live birth 2 Pregnant at til Unknown	Fetal d	eath 3]Ectopic p] Other (s		y				23d. Date Mor	e of delive	ery Day Year
	quires that the signed by all did be detact	Completed by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the underlying cause given in Part I.													
	× d°s											24a. Wa auto peri 1∐ Yes	s an opsy formed? 2 X N	d	leath?	psy findings available mpletion of cause of 2 No
Vital	Physician: The la r this certificate has ral director, page 2	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2X No	Hospital:	1 ☑ Inpatient	2015	R/Outpatie	at 3 🗆 D	OA Oth	er.		h (Check only	7	e Doth	or (Coosif	6.4
Ö	nding Phy: tth. r: After this e funeral di	ation: To	27. Manner of Death 1 X Natural 5 Pendir 2 Accident investi	ng	Date of Injury (Month, Day	2	8b. Time o Injury		28c. Injui Wor	4 L N		ome 5 Res 28d. Describe				γ)
DIVIS	Hospital or Attending 14 hours after death. Funeral Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could 4 Homicide determ	inod 200.	Place of injury building, etc.	- At hom (Specify)	e, farm, sti	reet, factor	y, office			28f. Location City or To	(Street a	and Numberte)	er or Rura	al Route Number,
	e Hospital of 24 hours at Euneral Eletely filled i	dical (ng Physician: 7 Examiner: On and		xaminatio										

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nidhi Singh Sikhanj, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850

DHMH 17 Rev 1/2001

29c. License number

D64560

29d. Date signed (Month, Day, Year)

August 18, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Joseph Ric 5. Social Security Number Baltimore 8. Date of Birth (Month, Day, Year) 6.-Sex If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 ME Months Days 221-10-7214 Director 449 15 aryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n 1806 R iral", or Items 2 Examiner mu Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 ☐ Divorced Black "natural", the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) hiatr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 7 Is marked traumatic 2 (Cousin) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ns#3B permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau once, Geraldine 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Funeral Home 2222W. North Ave. Baltimore Md 21216 Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiomyopa /Medical Due to (or as a consequence of): **Examiner** oronary Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of). Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9∏Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an was autopsy performed?
Ves 22 No certificate has 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6. Other (Specify) Hospital: 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA After this Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a e Funeral I 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier within 24 hou

To the Fune

completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) Eutawst State Registrar

07-06176 Ma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

	For State Certific	nent of Health and Mental Hy cate of Death	Reg. No.	241/ 25
Physician/	egistrar Decedent's Name (First, Middle,Last)	· .	2. Date of Death Month Day Yea August 11, 2007	3. Time of Death 1159 hrs
lical Examiner 4	Mark Edward Brown a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County	of Death
	Johns Hopkins Hospital Social Security Number 6. Sex 7. Age (In yrs. last	Baltimore oirthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth (MM/DD/YYYY)	9. Birthplace (State or
uncia	214–98–1589 1 M 2 F 38	Months Days Hours Min.	07/15/1969	Foreign Country) SC
100 C		wn or Location		10d. Inside City Limits
nd show a	VA Roanoke Roan		Lin Overs of W	1 XYes 2 No
Maryland -28a-f shooled at once	0e. Street and Number	10f. Zip Code	10g, Citizen of W	
ith the M 23a or 2 23a or 2 23a or 2	3843 Woodleigh Road 11. Marital Status 12. Was Decedent Ever in U.S.	24017 13. Was Decedent of Hispanic Origin? (Sp.		e - American Indian, Black, te, etc.
5 2 2 3	1 XNever Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 X No specify:	Specify:	White
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215-0036 be filed within 72 ntal Hygiene rked other than ' ent, the Medical Be Complet	10 17. Father's Name (First, Middle, Last)	Laborer 18. Mother's Name	e (First, Middle, Maiden Surnam	
21215- Jid be filed Mental Hyg marked ott event, the	King Edward Brown	Carole	Jean Keywood	3
Ne ma	19a. Informant's Name/Relationship (Type, Print) Dawn Marie Lewis, Sister	19b. Mailing Address (Street and Number or 3843 Woodleigh Road,		
	20a. Method of Disposition 20b. Pla	ace of Disposition (Name of cemetery, ematory or other place)	Date 20c. Location	- City or Town, State
Baltimore, Dermit, Pages I at Department of He Important: If ite	1 Burial 2 X Cremation 3 Removal from State		20/2007 Baltin	ore, Maryland
Baltin permit, P Departme Importar injury or	2 nature of Funeral Servic Licensee M()1113	22. Name and Address of Facility	Skarda Funeral	Home
	23a. Part I. Ehter/the disease, or complications that caused the death. I	2829 Hudson Stree	or respiratory arrest, shock, or h	neart Approximate Inter Between Onset a
Physician Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic and metha		ATTANA JOHN SALAMAN Kalandaran	Death
caminer	or condition resulting in death) Due to (or as a consequence of)	- a	August Tool to	
e.	Sequentially list conditions, if any, reading to immediate b.			
ed nsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last United (or as a consequence of)			
und transit	d			
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit completed by Physician/Medical Ex	X UNPENDED #23a.27.28a-f. pe	ME. 2870. 8/22/07 TT	23d. Date	of delivery
876 tificate ing phy as the l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant in the past 12 months?	2 Fetal death 3 Ectopic preg	nancy Month	Day Year
ox 6876 eath certificat attending ph for use as the	past 12 months? 4 Pregnant at time of deal 1 Yes 2 No 9 Unknown 9 Unknown	th 5 Other (Specify)		
Division of Vital Records, P.O. Box 6876 rate or Attending Physician: The law requires that the death certificate ra after death. "In Director: After this certificate has been signed by the attending phyled in by the fineral director, page 2 should be detached for use as the ertification: To Be Completed by Physician/IM	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause given in Part I.		ntribute to the cause of death? 3 Probably 4 Unknow
s, P.C nires that n signed d be det			.	b. Were autopsy findings availa
Records, I The law requires ficate has been sig , page 2 should be Completed			autopsy performed?	prior to completion of cause death? 1 Yes 2 No
Rec : The l ificate l r, page	25. Was case referred to medical	26.Place of Death (Chec	1 Yes 2 No	1 Yes 2 No
/ital		ER/Outpatient 3 DOA Other Nur	sing Home 5 Residence	
of Ving Physical distribution of To on To	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury oc	curred
ivision Tor Attendi after death. Director: d in by the f	Fending Find 8/11/2007	unk	unk 28f. Location (Street and Nu	imber or Rural Route Number,
Division of spiral or Attending nours after death near Director: After tilled in by the fune Certification:	3 Suicide 6 X Could not be determined (Specify) apartment	me, farm, street, factory, office building, etc. nulti-family building		St. Baltimore, M
	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner: On the basis of examination a	death assured at the time date and place a	and due to the cause(s) and mand at the time, date and place, a	nner as stated. nd due to the cause(s)
To the Ho within 24 To the Fu completel	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date	signed (Month, Day, Year)
	Cardefallan	O.C.M.E.	August	12, 2007
6 V	Carony many me	111 Penn Street, Baltimore, MD 21	201	
State		ire It foots		
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DHMH 17 Rev 1/2001 OCME 2006

OCME

			1 - State Registrar	State of Man		inment of F tificate of			ene 2007	26743	
	Physici	an	1. Decedent's Name (First, Middle, Las	y				2. Date of Death Month	Day Year	3. Time of Death	
	/Medic		Loy Lee Capshaw					August	6, 2007	7:14 PM M	
	Examir	er	4a. Facility Name (If not institution, give				r Location of Deat	h	4c. County of Deat		
			373 Woodpoint Av 5. Social Security Number 6. Se		n yrs. last birthday)	If Under 1 Year	erstown	8 Date of Birth	Washingto	hplace (State or Foreign	
	Funeral Director			□M 257 F	44 Yrs.	Months Days	Hours Min.		(ear) Co 962 Ms	aryland	
	p _		Usual Residence of Decedent					110 13 1	702	,	
	aryia:	-	10a. State 10b. County		Oc. City, Town or Lo	cation				10d. Inside City Limits	
	Ne M	ecto	MD Washing	ton	Hager	stown				1 Yes 2 No	
	with	۵	10e. Street and Number 373 Woodpoint Ave	m110		10f. Zip Code	21740	109	g. Citizen of What Co USA	ountry?	
	ne 23	Funeral Director	11. Marital Status	12. Was Decedent Eve	r in U.S. 13. V	Vas Decedent of H		Specify Yes or No-	14. Race - Ame	rican Indian.	
21215-0036	should be filed within 72 hours after death with the Maryland and Menlar Hygene. The Hygene marked other than "neturel" or iteme 23a or 28e-f ehow marked other than "neturel" or iteme 23a or 28e-f ehow matte event, Ita Medical Exeminer man be collified at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	11	Yes, specify Cuba	an, Mexican, Puèr Specify:	to Rican, etc.)	Black, White Specify: Wh	e, etc.	
2-0	72 ho	Completed	15. Decedent's Edi (Specify only highest grad	ucation	16a. Deced	ent's Usual Occup	ation	rking 16	3b. Kind of Business/	Industry	
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7	iled v tygie ther ti nt, in		17. Father's Name (First, Middle, Last)	3	cle	rical	10. Matheda Ne	ma (Einst Middle Mi	insurance		
and	d be f anta! h	Be c	Dustin Dale Welch	'n				me <i>(First, Middl</i> e, <i>Ma</i> ia Jean Bu			
Maryland	Shouli mark mati	၉	19a. Informant's Name/Relationship (T		19b. Mailin	a Address (Street			City or Town, State, Z	Zin Code)	
S	alth ar		Steve Capshaw/sp					Hagerstown			
altimore,	permit. Pages 1 and 2 should be Deperment of Health and Menia Important: If Item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☒ Donation 5 ☐ Other (Specify,	Idilioval Iloni Otato	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place	ce)	Date 20	Oc. Location - City or	Town, State	
Balti	permit. Depertmine imports any inju		21. Signature Funeral Stylice Licens		tor St.	Name and Addre ate Anato ltimore,	ss of Facility Omy Board MD 2120	1 655 W. E	Saltimore	Street	
	Physician Medical Examiner Medical Examiner Physician and	dical Examiner	23a. Part1. Enter the disease. of composition, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a co	onsequence of):			CAN CON		Approximate Interval Between Onset and Death	
	tificate ig phy as the			d							
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ဝ ၁	~ D 76							24a. Was an	24b. Were au	topsy findings available	
r	The ate h page	E						autopsy performe	d? death?	completion of cause of 2 No	
VItal	ician: certificel rector, p	Be	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only one)			
5	× 50	၉	1 □ Yes ZDWo	fospital: 1 ☐ Inpatient	2 ER/Outpatient		4 Nursing F	lome 50 Residen	ce 6 Other (Spec	cify)	
	After I	on:	27. Manner of Death 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injun Worl		28d. Describe how	injury occurred		
<u>s</u>	Attending It death. ector: After by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		***		Yes 2 □No				
=	urs after urs after urs after urs Direction	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	Specify)			City or Town,	· · · · · · · · · · · · · · · · · · ·		
	To the Hospital or Attending Ph within 24 hours attendesth. To the Funeral Director: After th completely filled in by the funeral	Medical	one)	sician: To the best of m ner: On the basis of exa and manner stated.	amination and/or inv	estigation, in my o	pinion, death occu	irred at the time, date	and place, and due	to the cause(s)	
	T with	~	29b. Signature and title of certifier		m	29c. Licenso	e number	290	I. Date signed (Month	n, Day, Year)	
		-	20. Name and address of access in	moleted source of the	Land)	4641	3	-Mapust	14,200/	
			30. Name and address of person who co	Annieled cause of death	(IIIII Z3a) (Type, F	200	120	CT . 1 1	free or not	AIN MAIN	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	20.0	KIT	_ ()	Traderil	WWW NU	
	Registr	ar	AUG 2 1 20	1117	H R	and a			1	2114	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** MACK 7:30 A M HARLES AUGUST 20 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SCHOOL UTHERVILLE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 → M 2 □ F 218-18-0176 Director 10/18/19 MARYIAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 ☐ No BACTIMORE Funeral Directo MARYIAND UTHERVILLE 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 21093 USA or items 23a CHOOL 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 tes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify: 3 Widowed 4 Divorced WHITE "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) XHOOLS and Mental Hygie is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NORMAN 2 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau once. MO ANET LANE LUTHERVILLE MACK 20a. Method of Disposition Date 20c. Location - City or Town, State August 22 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐ Removal from State FUNERAL Chapel 2007 TOREST HILL, MARYLAND 21. Signatur Filt Fral Service Liv FUNERAL & CREMATION CTR. TNATIVES RO. TIMONIUM, 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the gode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causi on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualty for sels consequence off Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 No 2 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 2 ☐ Accident 1 ☐ Yes 2 No within 24 hours after death To the Funeral Director: completely filled in by the i 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

19

32. Registrar's Signature

29c. License number

267

29d. Date signed (Month, Day, Year)

07-06252

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

mes L. Cronin	1	1- For State Certificate of Death Reg. No. Registrar 13 Time of Death Registrar 14 Death of Death Registrar 15 Dea	57.
Physicia edical Exami	an/	1. Decedent's Name (First, Middle,Last) James L. Cronin, III 2. Date of Death Month Day Year August 14, 2007 3. Time of Dea	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital 4c. County of Death N/A	
Funeral Director		5. Social Security Number 212 84 0950 1 X M 2 F 37 Yrs. 6. Sex 7. Age (In yrs. last birthday) 4. Months Days Hours Min. 4.	and
id how any <u>ce,</u>		Usual Residence of Decedent 10a. State	
the Maryland a or 28a-f show tified at once.	Director	10e. Street and Number 7227 Judy Road 10f. Zip Code 21060 10g. Citizen of What Country? U.S.A.	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygers 27 is marked other than "naturalt", or items 23a or 28a-f sho manic event, the Medical Examiner must be notified at once	y Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bla White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Specify: White	ick,
21215-0036 Idbe filed within 72 hours after defined Hygiene, narked other than "natural", event, the Medical Examiner.	ompleted by		1
21215-0036 uldbe filed within 7 Mental Hygiene. marked other than	Be Cor	James L. Cronin, Jr. Jane L. Smith	
ore, MD 21215-003 es I and 2 should be filed within of Health and Mental Hygiene. If item 27 is martic douber if the traumatic event, the MEG	TOE	19a. Informant's Name/Relationship (Type, Print) James L. Cronin, Jr. / Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2p Code) 7227 Judy Road Glen Burnie, Maryland 21060	
s I and street If item		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Park 20c. Location - City or Town, State 08/18/2007 Glen Burnie, Ma	ıryla
Baltimo permit. Page Department of Important: injury or oth	~ 5	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland	2122
Physician /Madical xamine		23a/Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Onset and
-	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):	
60, iate be executed bhysician and be burial - transit	Medical E		
Division of Vital Records, P.O. Box 68760, or the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and the control of the funeral physician and control of the c	Physician/Me		Year
P.O. Be s that the degree by the greed by the greed by the	by Phy	1 Yes 2 ✓ No 3 Probably 4	
Division of Vital Records, P.O. Box 6870 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending processing that the formeral director near 2 should be detached for use as it.	Completed	24a. Was an autopsy performed? 1 Ves 2 No 1 Ves 2	
al Re nn: The ertificat	Be Co	1) 25, was case referred to medical	
Vita Prysici rthis co	ToB	1 V Yes 2 No Inpatient 2 Erooupation of Injury at Work? 28d, Describe how injury occurred	
Sion of Attending F death.	fion:		
Divisi tal or Att rs after de at Direct	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined Cpecify) Major Road / Highway 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) (Specify) Major Road / Highway 28f. Location (Street and Number or Rural Route Number or Town, State) NB Rt 29 N of Rt 198, Burtonsville, MD	Jmber, Cit
Divis To the Hospital or A within 24 hours after To the Funeral Dire	Medical Co		
To vitl	Med	29b. Signature and title of certifier O.C.M.E. 29d. Date signed (Month, Day, Year August 16, 2007	ar)
17		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	Stat	te 31. Date filed (Month, Day, Year) 2. Registrar's Signature	
Reg	istra	ar AUG 2 1 2007 Augustus 10.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Davis Chew Stella 10:15p 2007 /Medical August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Future Care Nursing Home If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Yrs. 0i 17 29 MD Director 215-24-9606 78 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County Baltimore 1X Yes 2 No NA MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21229 S Athol Street Funeral permit. Pages 1 and 2 should be filed within 72 hours atter deal Department of Health and Mental Hygiene. Important: If then 27 is marked other them any Injury or other traumment. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 20 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: Black Q Q 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Various Company 7th grade na Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jane Davis ္ပ James Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Leverage Road, Churchill, Md 21623 Richard Edward Jenkins-Nephew 401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/21/07 Baltimore, Md Mt. Zion Donation 5 Other (Specify) 22. Name and Address of Facility
March F/H West 21. Signa urg of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. P. nt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imp ediate Cause (Final di ease or condition resulting in death) Due to (or as a nse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequent Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform

Physician /Medical Examiner

28a-f show

the

death

notified

ms 23a or 7 with

7 Is marked other than "natural", or items traumatic event, the Medical Examiner mu

burial-tran physician the burial as I attending p use for signed by the a Completed certificate has b irector, page 2 sl Be Certification: To this funeral After in 24 hours after the Funeral Director: Af

the Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760.

Records,

Division or Vital

25. Was case referred to medical examiner? 2 No 1 ☐ Yes

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide

28a. Date of Injury (Month, Day Year) 28b. Time of 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

and manner stated.

Other: Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 1 Tyes

2 🗆 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the de

e No

28d. Describe how injury occurred

26. Place of Death (Check only one)

29b. Signature and title of certifier

4 Homicide

29a. Certifier

Medical

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2□ No

1 TYes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

31. Date filed (Month, Day,

32. Registrar's Signature

within 24

4b. City. Town, or Location of Death

State of Maryland

/ Department of Health and I	Mental Hygiene	
Certificate of Death	Reg. No. 2	2675
	2. Date of Death	3. Time of Death

AUGUST

6:05 AM

16 2007

4c. County of Death

Physician	
/Medical	
Examiner	

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

EULA

Funeral

Director

show 23a or 28a-f shovust be notified at permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must bonce.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

attending physician and for use as the burial-transit requires that the death certificate be executed signed by the and be detached for has certificate To the Hospital or Attending Physician: pletely filled in by the funeral within 24 hours after death. To the Funeral Director: After

Records, P.O. Box 68760,

Division or Vital

GLEN BURNIE HEALTH AND REHABILITATION GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/6/1922 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Months Days Hours Min WEST VIRGINIA 1 □ M 2 🕅 F 85 215-32-8529 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐XNo MD ANNE ARUNDEL Director GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1612 PLEASANTVILLE DRIVE 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□ Yes 2戸No Specify. Specify: WHITE ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ASSEMBLY WESTINGHOUSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ISOM LAMBERT ည MARY ALICE PAINTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JEROME CALHOUN - HUSBAND 1612 PLEASANTVILLE DR., GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State CEDAR HILL CEMETERY 8/21/2007 BROOKLYN PARK, MD 4 Donation 5 Dother (Specify) of uneral Service Licensee 22. Name and Address of Facility SINGLETON FUNERAL HOME P.A. GLEN BURNIE, MD 21061 1 2ND AVE. S.W., molido Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ISEAS E ORONAR disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Nknown 2N SUDA 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Sursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 ☐ Medical Examiner: On the basis of exam and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner st 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2

Registrar DHMH 17 Rev 1/2001

State

KICHARD

31. Date filed (Month, Day, Year) AUG 2

4710 CENNING

32. Redistrar's Signature

BRIE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 15, 2007 Marjorie D. Collins August 1326 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 619 West Lynfield Drive Rockville Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 😾 F 476-16-5472 84 Director July 20, 1923 Minnesota Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show the tranumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1XIYes 2 □ No Director Rockville Maryland Montgomery 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 619 West Lynfield Drive 20850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specify: White 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Law Office/ than the M Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Bar Association 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Daw Grace Hutchins မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tra 1207 Roland Drive, Herndon, Virginia 20170 Kathleen M. Miller / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 22, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Gate of Heaven Cemetery 2007 4 Donation 5 Dother (Specify) Silver Spring, Maryland 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee M01473 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiac Arrythmia Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Mitral Valve Insufficiency Years Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dire to for as a consequence of). law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 4☐Pregnant at time of death 9☐Unknown Month Day 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia, Mild 1 ☐ Yes 21X No 3 ☐ Probably 4 ☐ Unknown Completed Hyperlipidemia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 1∐ Yes 2 No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director; After this

filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D21392 August 17, 2007 30. Name and address of person who completed cause of death (Hern 23a) (Type, Print) M.D. 1201 Seven Locks Road, #110, Rockville, Maryland 20854 Patricia Kellogg, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1.26 per doc 10e f per flh g872 10-11-07 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death R. Chester Anna Month **Physician** U9 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 9./Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 2\ F 19-01-256 Director Usuel Residence of Decede filad within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location If item 27 is marked other then "naturel", or items 23s or 28s-1 show or other traumatic event, the Modical Examinar mast be notified at 1 Yes 2 No Director more 10f. Zip Code 21217 10g. Citizen of What Country? 10e. Street and Number 1804 N Monroe St. Be Completed by Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pagas 1 and 2 should be filad within nant of Haalth and Mantal Hygiana. Int: If item 27 ie marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ an 19a. Informant's Name/Relationship (Type, Print) (Niece) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory 1 ⊠.Burial 2 ☐ Cremation 3 Removal from State 1200 permit. Paga Dapartmant of important: If eny injury or once. ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Eacility

JOS - h L L

2.2.2.2. W North 21. Signature of Funeral Service Licenses uneral Home Basto. 222 W. North Ave 23a. Part f. Enter the distance or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) orcetal Cance **Physician** 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physicien: Tha law requires that the daath carificals be axecuted sate has baan signad by the attanding physician and paga 2 should ba datached for usa as tha burlat-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical for usa as tha IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Wes decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Aftar this cartificate has autopsy performed? 1 Yes 2. No funeral diractor, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Niece's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Thesidence Checify) 1 ☐ Yes 2 ☐ No Certification: To Home 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No daath. investigation within 24 hours aftar daatt To the Funerel Director: complataly fillad in by tha 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00051189 864107

Registrar
DHMH 17 Rev 1/2001

State

Baltimore

702

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Barm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2007 **Physician** 17, 10:18 Am DUARTE Aug MILDRED /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A 1650 woodbourne Ave. Apt.207 Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 X 90 219-12-8390 May 29,1917 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1√Yes 2 No Director N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ss 1 and 2 should be filed within 72 hours after death with of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or: other traumatic event, the Medical Examiner must be n 21239 U.S.A. 1650 Woodbourne Funeral Ave. 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) private home 12th cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stella Jones ၉ Domingo Duarte 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 1404 Winston Ave. Baltimore, MD 21239 Luther Conrad Slacum/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 Burial 2 □ Cremation 3 □ Removal from State Aug24,2007 Baltimore, Md KingMemPark 4 Donation 5 Other (Specify) 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTIMORE, 21. Signature of Funeral Service Licens MD 21213 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami burial-trar and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Hypertension 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Chronec kidney Failure 24a. Was an page 2 s 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1 inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes မ After this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

certificate be executed Box 68760, Division or Vital Records, P.O.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dii

DHMH 17 Rev 1/2001

State Registrar

Medical

29a. Certifier

29b. Signature and title of

Loch Raen 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Balt: more mo 21239

ORIGINAL

29d. Date signed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

8-20-07 H0059388

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David 5. Weismon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. MEND TITMS perFH (870 87/9/0/ US State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vear AUGUST 16, 2007 DAVIS 4:35 PM HOMAS LEON 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE REHAB AND EXTENDED CARE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Nu 1947 7. Age (In, yrs. last birthday) Birthplace (State or Foreign Country) 15 M 2□F Yrs. (arolen North Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. Count 1 Yes 2 No timore De ma. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA rossing 12. Was Docadent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces?
1 ☑ Yes 2 ☐ No 1 Never Married 2 Married 13/ac 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ectrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thu Dave Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WIFE Frances Lee Davis Bridge Crossing Rd. APTG. ESSEX, MD. 21221 1210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State -24-WUNDMILLO, MD * 4 ☐ Donation 5 ☐ Other (Specify) ruan forest vet. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Nancy m. wallace; une 150E10, MO, 41229 Approximate
Interval Between
Onset and Death
ONE YEAR 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he trifailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) (ancer lung cell Non Small Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐Pregnent at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 PYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed the burial-transit use as t signed by the attending I be detached for use as Ö Records, P. should page 2 s certificate of Vital Physicien: director, After thi funeral of Attending Division death, Director: /

Physician

/Medical

Examiner

Funeral

Director

in then "natural", or Items 23a or 28e-f show The Medical Examiner must be notified at

within 72 hours after

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permit. Page Department of Important: If any injury or once.

Physician

/Medical

Examiner

Completed by Physician/Medical

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Medical Certification:

4 - Homicide

(Check only one)

29a. Certifier

Examiner

Mental !

Pages 1 and 2 should

or other traumatic event,

Maryland 21215-0036

Baltimore,

Director

Funeral

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Be Completed

filled in by within 24 hours a To the Funerel the Hospitel 4

State Registrar 29b. Signature and title of certific

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0032548

and ad s of person who completed cause of death (Item 23a) (Type, Print) North 10

Greene Street Baltimore

31. Date filed (Month, Day, Year)

Olvin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 1 - For State Registrar

68760,		Baltimore, Maryland 21215-0036
rtificate be executed	Phy /N Exa	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
ng physician and	ysid led am	Department of negatir and wenter in year. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
as the burial-transit	cia ic	any injury or other traumatic event, the Medical Examiner must be notified at

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	Examin	er	,	(If not institution, gi		ber)		4b. City,		Location Bethe				inty of Death	7	
		A	5. Social Security I			7. Age (In yrs.	last birthday	If Under			24 Hrs.	8. Date of Birtl	1	0 Dietho	loss /State of Fo	reign
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e, 1	s 1 and 2 should be filed within 72 hours after death with the Marylar f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Dis			20b. I	Place of Disp			;		Date		on - City or T		
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89)	ath certificate be executed ttending physician and or use as the burial-transit	an/Medical	IF FEMALE:							-						
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, P.O	The law requires that the dea ate has been signed by the at bage 2 should be detached fo	/ Ph	Part II. Other sign	nificant conditions	contributing to de	ath but not res	ulting in the	underlying	cause giv	en in Part	l.	23e. Did to	obacco use	contribute to	he cause of deat	th?
rds	w requires to been signer should be a	d by						1 🗆 `	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆			nown				
000	aw requ is been 2 should	plete										24a. Was	an 2	4b. Were aut	opsy findings ava empletion of caus	ailable
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1	52		30. Name and ad	Idress of person wh	completed cause	e of death (Ite	m 23a) (Type	2624	- W.	301.	18111	AUE #	661	BETT	ESDA Y	\mathcal{N}_{i}
ì	Sta	ate	31. Date filed (Mo	onth, Day, Year)	32. Re	egistrar's Sign	ature	9	PVI	J 40/	on N	11.00	/	20	816	
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97-06381 George David Fro		otato of that your a repair.		ealth and		ygiene	20		
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Physicia Medical Examir		George David Fr	aahamaan		1.0	Month August 18,	Day Year	0146 hrs	
e e	IG.	4a. Facility Name (if not institution, give street and number)			ocation of Death		4c. County of Deat		
		Harbor Hospital Center		altimore	ocation of Death				
		5. Social Security Number 6. Sex 7. Age (In yrs. last		Under 1 Year	If Under 24Hrs	Pote of Birth	N/A. 1(MM/DD/YYYY) 9. Bi	rtholace (State or	
Funeral Director		212 70 6020		onths Days	Hours Min	-	Forei	nn	
Director		212 /8 6829 1XM 2 F 46	Yrs.		7-	08/14/	1961 00	ountryMaryland	
		Usual Residence of Decedent						10d. Inside City Limits	
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f (q faryland 28a-f show 1 at once.	ō					51 41			
Mary Mary	Director	10e. Street and Number	10f	. Zip Code		. 10	g. Citizen of What Cou	intry?	
after death with the Maryland all", or items 23a or 28a-f sho iner must be notified at once.		442 Seward Avenue		21225			U.S.A.		
with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?			anic Origin? (Sp Mexican, Puerto	pecify Yes or No-	14. Race - Ame White, etc.	rican Indian, Black,	
death rr ite must	Š	1 Never Married 2 Married 1 Yes 2 X No	ii res, s	pecify Guban, i	wexican, Fuerto	Nicali, etc.)	vvinite, etc.		
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ours	9	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's U		on (Give kind of on NOT use ret		16b. Kind of Business	/Industry	
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5-0 led w othe		17. Father's Name (First, Middle, Last)		18		e (First, Middle, M			
21 be fi rrked	B	George T. Freeberge				dred Nor			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygene. Important: If item 27 is marked other than "natur- injury or other travmatic event, the Medical Exam	2	19a. Informant's Name/Relationship (Type, Print) George T. Freeberger / Father	-	,			ber, City or Town, Stat		
MC d 2 sl (th ar n 27			442 Sew				re, Marylan		
Fe Te The Tree of The Tree of The Tree of Tree			ace of Disposition ematory or other p		etery,	Date	20c. Location - City of	r Town, State	
Pages ent of			n Haven	Mem. Pa	ark 08,	/25/2007	Glen Bur	nie. MD.	
Baltipoermit. Departmingury o		21 Signature of Funeral Service Licensee		and Address of	of Facility Go	nce Fund	eral Servi	CO P A	
E E E E	H	Aman Snamususki			ie Highv	vay Bali	timore, Ma:	ryland 21225	
Physician	_1	23a. Part I. Enter the died se, or complications that caused the death. D failure. List only one cause on each line.	o not enter the m	ode of dying, s	uch as cardiac o	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and	
/Medical		Immediate Cause (Final disease a. Alcohol and quetia	arine into	xication				Death	
Examiner		or condition resulting in death) Due to (or as a consequence of):							
		Sequentially list conditions, b						ļ	
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Ox 68760, leath certificate be e e attending physicie for use as the buria	Jug	23b. Was decedent pregnant in the past 12 months?	2 Fetal de	eath 3	Ectopic pregn	ancy	Month	Day Year	
ox 6 eath cer attendi	ici	4 Pregnant at time of death	h 5 Other	(Specify)			İ		
Be degree of the g	Physician/Med					00a Did ta	bacco use contribute t	a the course of death?	
1 of Vital Records, P.O. B. Ing Physician: The law requires that the d. After this certificate has been signed by the funeral director, page 2 should be deached		Part II. Other significant conditions contributing to death but not resi	uiting in the under	Tying cause giv	ven in Part i.		2 ✓ No 3 Pr		
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w req	Set					24a. Was a autops	sy prior to	autopsy findings available completion of cause of	
eco he la ate ha	E					perfor 1 ✓ Yes 2			
rrific tor, p		25. Was case referred to medical		26.Place	of Death (Check	only one)			
/ita	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ E	R/Outpatient 3	DOA	Other Nursi	ng Home 5	Residence 6 Oth	er:	
of Ning Phy	 5		28b. Time of Injury	28c. Injury	at Work?	28d. Describe h	now injury occurred		
ath.	tior	Pending Fpd 8/18/2007 I	es 2 X No	unk					
rAtt	lica	28e. Place of Injury - At hom	28f. Location (S	Street and Number or F	Rural Route Number, City				
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Division of Vital Records, P.O. Box 68760, To the Hospiral or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn									
To To Col	Me	and manner stated. 29b. Signature and title of certifier		29c. License	number		29d. Date signed (M	lonth, Day, Year)	
1 .09.		WALAIN YM		O.C.N	Λ.E.		August 18, 200	7	
They		30. Name and address of person who completed cause of death (Item 2	(3a)	L					
0-1		Susan Hogan MD. Assistant Medical Examiner	111 Penn S	treet, Baltir	more, MD 2	1201			
St	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	Charle	,					
Regist		5 1 1 1 1 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1						

-1874/1867, Jo 07-06222 JNK UNK		Please Type of State	or Print in Black Ind of Maryland / Depar <i>Cert</i> i		Health and		ygiene	20	07 2875
Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle,Las			To		2. Date of Death	No. Year 2007	3. Time of Death 2101 hrs
		4a. Facility Name (if not institution, giv Route 50 East at Route 70	e street and number)		b. City, Town, or L Springdale	ocation of Death		4c. County of E Prince Ge	
Funeral Director		5. Social Security Number 6. Se 385-74-0070 1 Usual Residence of Decedent	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min	_		B. Birthplace (State or Coreign Washington Country)
Maryland 28a-f show any d at once.	tor	10a. State 10b. County 10e. Street and Number	10c. City, T Ba	own or Location	one	and any depth of	Lio	Cisi	10d. Inside City Limits 1 Yes 2 No
death with the Nor items 23a Gr	by Funeral Director	1525 North 5 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Ye	10f. Zip Code 2 1 2 Decedent of Hisp s, specify Cuban, Yes 2 No	Mexican, Puerto	pedfy Yes or No- Rican, etc.)	14. Race - A White, e	American Indian, Black,
5-0036 led within 72 hours after Fygiene. other than "natural", the Medical Examiner	Completed	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	Ollege (1-4 or 5+)	during mo	's Usual Occupation st of working life. I	Pers	red)	Auto	Parts
nore, MD 21215-0036 ges I and 2 should be filed within 72 nt of Health and Mental Frygiene. F. If liem 27 is marked other than sother traumatic event, the Medical	To Be Co	17. Father's Name (First, Middle, Last) Tohnie Fle 19a. Informant's Name/Relationship (T	teher SR.	19b. Mailing	Address (Street	8. Mother's Name Sond and Number or	Gra L	er, City or Town,	State, Zip Code)
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Fygene. Important: If item 27 is marked other tinjury or other traumatic event, the Med		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licen	Removal from State	ace of Dispositematory or other		etery, 8	Date /20/07	Baltin	ty or Town, State
Physician /Medical ixaminer			dications that caused the death. Death ine. Multiple Injuries Due to (or as a consequence of):		# TOS (ych as cardiac c	or respiratory arres	O A A1 t, shock, or heart	Approximate Interval Between Onset and Death
vecuted 1 and - transit	al Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):			* 5.5			
Box 68760, s death certificate be executed the attending physician and ed for use as the burial - transit		UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	AMENDED 23c. If yes, outcome of pregna 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Feta	al death 3 er (Specify)	Ectopic pregna	ancy	23d. Date of de Month	livery Day Year
cords, P.C law requires that has been signed 2 should be dete	Completed by Pr	Part II. Other significant conditions	contributing to death but not resu	ulting in the ur	nderlying cause giv	ven in Part I.		2 No 3	te to the cause of death? Probably 4 Unknown re autopsy findings available or to completion of cause of th? Yes 2 No
Vital Rechysician: The this certificate difficetor, page	e Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2 E	R/Outpatient		of Death (Check Other Nursin		esidence 6 🗸	Other: Scene
<u></u>	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation	FOUND: Day, Year) Found 12, 2007 2	8b. Time of In FOUND: 2107 hrs	1 Ye	es 2 🗸 No	28d. Describe ho Driver auto m	otorcycle coll	
		3 Suicide 6 Could not I determined 4 Homicide 29a. Certifier 1 Continues Physicial Continues Physician Physician Continues Physician Phy	(Specify) Major Road	/ Highway	····		or Town, Sta Route 50 East a	te) at Route 704, S	
To the Hospital within 24 hours To the Funeral completely filled	Medical		an: To the best of my knowledge, On the basis of examination and and manner stated.			death occurred a	at the time, date ar	nd place, and due	to the cause(s) (Month, Day, Year)
	ŀ	30. Name and address of person who of Susan Hogan MD. Assis	ompleted cause of death (Item 23	•	Street, Baltin	nore, MD 21	<u> </u> 201		
Sta	ite	31. Date filed (Month) Pay Yeer)	007 32. Registrar's Signature	a diff	sti)	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** AUGUST 2007 9:30P trances /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Medical Center Joseph 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M 2**X** F 214.22.7243 03/01 Director Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at MD 1 Yes 2 No 13a Itimone Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Matthews Street USA 21202 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner ,o 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Black er than "natural", o , the Medical Exan ģ Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Gordonio Seafood College (1-4or 5+) Elementary/Secondary (0-12) of Health and Mental Hygiene. If item 27 Is marked other than or other traumatic event, the M COOK 11 th grade Kestaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mc Mækur Andrender Coleman John 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. ND 21212 Avenue Foster Floyd Dakland Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Surial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State Windsor Mill, MD Memorial Park 08/21/07 ughn C. Greene Funeral Sovos 21. Signature of Funeral Service Licensee au Baltimore MD 21212 Koad 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DFIYS Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION **Physician** ACUTE /Medical Due to (or as a consequence of) DAYS **Examiner** ACUTE RENAL FAILURE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 4□Pregnant at time of death 9∏Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ icate has been sig , page 2 should b 1 Tyes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 24a. Was an autopsy certificate Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu hours after death

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

CEBALL

DRIVE TOWSON, OSLER 7601 D. 32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of der th (Item 23a) (Type, Print)

.05

29c. License number

D25886

29d. Date signed (Month, Day, Year)

21204

MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			A COL	partment of Health and Mental Hygiene Pertificate of Death Reg. No. 0 0 7 26761
	Physici /Medio		1. Decedent's Name (First, Middle, Last) EDWARD FOY	2. Date of Death Month Day Year Accest 2017 3. Time of Death 5.27 4 M
	Examir Funeral	er	4a. Facility Name (If not institution, give street and number) GESS'S PELLING PARKWAY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	4b. City, Town, or Location of Death Acc County of Death Acc County of Death Acc County of Death Acc County of Death Acc County of Death Acc County of Death B. County of Death Acc County of Death B. County of Death Acc County of Death B. County of Death
	Director		056-12-1396	Sept. 19,1919 New York
	he Maryla 28a-f shov ctifical at	Director	10a. State 10b. County 10c. City, Town or Baltimore	2 1XIYes 2 □ No
9	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: if itam 27 Is marked other than "netural", or itams 23e or 28e-f show injury or other traumatic event, the Medical Exercities triust be rigitied at a.g	Funeral	4207 Raspe Ave	10f. Zip Code 21206 3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 Yes Specify:
Maryland 21215-0036	filed within 72 hours Hygiene. Athar than "natural", ant, the Medical Exa	Completed by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	coedent's Usual Occupation live kind of work done during most of working a. DO NOT use retired) ntenance Manufacturing
yland 2	should be filed within nd Mental Hygiene. i markad othar than 'umatic evant, the Me	To Be Co	17. Father's Name (First, Middle, Last) Robert Foy	18. Mother's Name (First, Middle, Maiden Sumame) Caroline Tonery
e, Mar	os 1 and 2 sho of Health and 1 itam 27 Is mu r othar traum		Lucille Foy-Wife 4207	7 Raspe Ave Baltimore, MD 21206 Date 20c Location - City or Town, State On Page 1 Page 20c Location - City or Town, State
Baltimore,	permit. Pages Department of I Important: If its any injury or of		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	Crematory 8-21-07 Baltimore
Ba	Dermi Depa Impo any ir	L		22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Rd Baltimore, MD 21206 enter the mode of dying, such as cardiac or respiratory arrest. Approximate
8760,	/Medical Examiner bhysician and street be executed with street is the burial-transit	Icai Examiner	shock, or hear tarrure. List only one cause on each line.	Interval Between Onset and Death AILURE AILURE
O. Box 6	that the death certific ed by the attending p detached for use as:	Physician/Medicai		3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Day Year
Δ.	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 X Probably 4 Unknown
al Reco	: The law re cate has bee , page 2 sho	Completed by	Dementra	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
Division of Vital Records,	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To tha Funaral Diractor. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	atlon; To Be	25. Was case referred to medical examiner? 1	of 28c. Injury at 28d. Describe how injury occurred
Divis	itai or Atta rs after de ra! Diracto led in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	City or Town, State)
	To the Hospital or A within 24 hours after To the Funeral Diractor Completely filled in b.	ledical	one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, and due to the cause(s) and manner as stated. investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
)	Con Twith	M	29b. Signature and title of certifier Wind Kley	29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)
0	1 1	Ц	30. Name and address of From who completed cause of death (Item 23a) (Typi 6 Fe/ N CAPPACCS St SU FE 4202 700	um bar 51344
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 1 2007 August Au	Goods.

07-05958 Eugene Green

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month 1931 hrs EUG ENE August 3, 2007 **Medical Examiner** 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 3401 Harford Road 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Country) Months Days Hours Director 25/ 35 1 M 2 F 5448 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County MD 1 Yes 2 No BALTIMOLE notified at once. after death with the Maryland Director 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number USA AVEN WOOD 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married Married 2 X No Yes If Yes, Give Year Yes 2 X No specify. Widowed Divorced narked other than "natural", event, the Medical Examiner ş 16a. Decedent's Usual Occupation (Give kind of work done Pages 1 and 2 should be filed within 72 hours and I lealth and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Co Baltimore, MD 21215-0036 ACT OR 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) marked 'EEN Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is m r tranmatic RAVENWOOD BALto Aut Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Important; If it injury or other X Burial 2 Cremation 3 Removal from State 8-11-07 mt Department Donation 5 Other Specify: permit. 21. Signature of Funeral Service Licenses 431 E. Ol. VERS. A WEATHERFIE. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. M. dical Death Narcotic intoxication Immediate Cause (Final disease Sxaminer Due to (or as a consequence of) or condition resulting in death) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Physician/Medical Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and X UNPENDED attending physician or use as the burial AMENDED, 27,28a-f, perME, g871, 9/7/07 TI Division of Vital Records, P.O. Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 2 No 1 V Yes Yes 2 this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 Yes No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 28b. Time of Injury 27. Manner of Death Certification: within 24 hours after death

To the Funeral Director: A
completely filled in by the fun Natural 1 Yes 2 X No Pending Fnd 8/3/2007 FNd 6:50 pm unk 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide or Town, State) house determined (Specify) 3401 Harford Rd. Raltimora_MO Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E August 4, 2007 30. Name and address of Jerson who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. Assistant Medical Examiner

State Registrar

31. Date filed (Month, Day, Year)

AUG

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Guiffrida Jane /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Yown, or Location of Death 4c. County of Death Examiner ade If Under 1 Year B. Date of Birth (Month, Day, FEB 26 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Months Days Hours 1923216-18-7467 84 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 1 Yes 2 No Director MD Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ms 23a must b 7 Perdale Court 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █No If Yes, Give Year or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or iten edical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Completed by Specify: 3 ✓ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Federal Elementary/Secondary (0-12) College (1-4or 5+) Clerk Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marlowe ၉ Nanny Mae Austin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Perdale Court, Perry Hall, MD Frank Guiffrida - son 21236 Saltimore, 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of HIMportant: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 8/21/2007 Baltimore, MD 21. Signature of Funeral Service Licensee Steven H. ²² Name and Address of Eacility Cremation Society of Maryland, 299 Frederick Road, Baltimore, Williams 4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and the burial-trai Due to (or as a consequen-Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 22 No certificate has 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 2 KER/Outpatient 3 DOA 1 ☐ Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital

> State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

Year,

DHMH 17 Rev 1/2001

29c. License number

Franklin Square.

29d. Date signed (Month, Day, Year)

07-06390

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ohn Gasque		State	of Maryland / Depa		ilth and Mental F	-lygiene		7 00 70			
Dh		Registrar 1. Decedent's Name (First, Middle,La		tificate of Dea	ui	Reg. I	No. [a.	3. Time of Death			
Physicia Medical Exami		John	(7a	Shue		Month Da August 18, 2	ay Year 007	0703 hrs			
		4a. Facility Name (if not institution, gi University Hospital	ve street and number)		, Town, or Location of Dea imore	th	4c. County of Death				
Funeral		Social Security Number 6.8	Sex 7. Age (In yrs. Ia	est birthday) If Un	der 1 Year If Under 24H		MM/DD/YYYY) 9. Birt	hplace (State or			
Director		215-86-1515 1	M 2 F 37	Yrs. Mon	ths Days Hours M	in. 7-17.	- 1970 Coi	nylyhy land			
any		Usual Residence of Decedent 10a. State 10b. County /	10c. City,	Town or Location				10d. Inside City Limits			
* .	7	My N/A	4 Bu	Himore				1 Yes 2 No			
th the Maryland 23a or 28a-f show	Director	10e. Street and Number	1'		ip Code	10g.	Citizen of What Cour	•			
death with the Maryland or items 23a or 28a-f she must be notified at once	al Di	1010 W. Bal	12. Was Decedent Ever in U.	S 13 Was Decer	21223 dent of Hispanic Origin? (Specify Ves or No.	U.S. A.	can Indian, Black,			
feath w r items	Funeral	1 Never Married 2 Marrie	Armed Forces	if Yes, spec	cify Cuban, Mexican, Puer	to Rican, etc.)	White, etc.				
safter o	by F		d If Yes, Give Year or Dates:		2 No specify:		Specify: 13 C				
2 hours "naturi		15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)		al Occupation (Give kind o orking life. DO NOT use re		b. Kind of Business/li	ndustry			
15-0036 filed within 72 hours after 1 Hygiene. ed other than "natural", c.	Completed	12		Main	tenance 18. Mother's Nar		Educati	on			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Las		- 10	18. Mother's Nar Burbu	me (First, Middle, Maio					
212 ould be I Menta marke	To Be	19a. Informant's Name/Relationship	sque Sr	19b. Mailing Addres	ss (Street and Number o	r Rural Route mbe		, Zip Code)			
mand 2 sho (call h and 2 tem 27 is traumati		John W. Gasq	ue Sr. tather	13302 6	idgate La	l. Palto	. lid. 212	211			
Ore, ges l ar t of Heg : If ite		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	Place of Disposition (Noterematory or other place	e)	Date 2	R. I.L.	rown, State			
Baltimore, permit: Pages 1 a Department of He Important: If it		4 Donation 5 Other Specification 21. Signature of Funeral Service Lice			nd Address di Facility	25-20011	Service	P.A			
Balt permit Depart Impor injury	4 (5	Carlton C. F	Tanglan	1 1701	McCulloh	St. Balt	· ly. 2/2	.17			
Physician /Medical		23a. Part I. Enter the disease, or confailure. List only one cause on	each line.		100		shock, or heart	Approximate Interval Between Onset and Death			
xaminer		Immediate Cause (Final disease or condition resulting in death)	End-stage renal Due to (or as a consequence or		Licated by coca	ine use					
·	<u>.</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence o	f\·							
	Examiner	cause. Enter Underlying Cause						-			
ecuted and transit		events resulting in death) Last	Due to (or as a consequence of	τ):				4			
ਤ ਕੇ ਲੋ	dical	X UNPENDED	AMENDED #23a,27.perME.g	871. 9/15/07	ਧਾ						
ox 68760, eath certificate be attending physic for use as the bu	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg	nancy Fetal deat		nancy	23d. Date of delivery	y Day Year			
Box 64 e death cert the attendir	sicia	past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at time of de					,			
D. Be t the der by the a	Phy	Part II. Other significant conditions	9 GIIKIIOWII	esulting in the underlyi	ng cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	d by					1 Yes	2 No 3 Prot	bably 4 🗸 Unknown			
cords, law requir has been s	plete					24a. Was an autopsy	prior to d	topsy findings available completion of cause of			
tal Recorian: The la certificate ha ector, page 2	Completed					performe 1 Yes 2		es 2 No			
of Vital Records, ng Physician: The law require Nfer this certificate has been si meral director, page 2 should b	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3	26.Place of Death (Chec		sidence 6 Other	r:			
n of V ding Phy 1. After th funeral c	n: To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe hov	v injury occurred				
Sion Attendi r death. cctor: /	atio	O 1 A Natural 5 Pending 1 Yes 2 No Investigation									
Division pital or Attendion ours after death. leral Director: /	rtific	Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Number, or Town, State)									
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the											
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examin	er:On the basis of examination a and manner stated.								
	2	29b. Signature and title of certifier		1	9c. License number O.C.M.E.		9d. Date signed <i>(M</i> o August 19, 2007				
		30. Name and address of person who	o completed cause of death (Item	1 23a)							
		· · · · · · · · · · · · · · · · · · ·	sistant Medical Examiner		eet, Baltimore, MD 2	21201					
S	tate	31. Date filed (Month, Day, Year)	32. egistrar's Signatu	K hack							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 16 40 gust \subset /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner to mU いか If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ▼ M 2 □ F Months Days **216-14-8783** Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f sh notified 1 ☐ Yes 2 ☐ No Directo <u>Baltimore</u> Maryland Baltimore Highlands Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 3 ury or other traumatic event, the Medical Examiner must be n 2 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1943 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 1945 3 X Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic MD Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Richard P. Greb Anna Dora Meyberger ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul T. Greb, Jr. / son 2921 Ohio Ave. Baltimore, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Memorial Park 08-20-07 Elkridge, MD 22. Name and Address of Facility
Ambrose Funeral Home of Lansdowne 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final **Physician** Insequence of): disease or condition resulting in death) /Medical Due to (or as a Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician; The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes e⊠No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1□ Yes 🐼 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Inpatient 1 ☐ Yes 2 ☐ X 0 Certification: To 2 ER/Outpatient 3 DOA Division or After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 10 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only within 24 and manner stated. To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2122 mmunds Ferry Ld Born 31. Date filed (Mont) State Registrar

State of Department #8, perffl, 872, 10/1/07 TT Certificate of Death

State Amend #8, perffl, 8872, 10/1/07 TT Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Las 2. Date of Death **Physician** siati son ller 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKIN SQUARE
5. Social Security Number 6. Sex edale DALTIMOre If Under 24 Hrs. 7. Age (In yrs. last birthday) 12/10/1931. Birthplace (State or Foreign **Funeral** Days Hours 251-46-8687 1**⋈**M 2□F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f show must be notified at 1 XYes 2 □ No MD **Funeral Director** ngham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 78 Insley 21236 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married "natural", or Baltimdre, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Be Completed in and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) perator 64h 17. Father's Name (First, Middle: Last) 18. Mother's Name (First, Middle, Maiden Surname) Haw Kins 2 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Pr Department of Health an Important: If item 27 is any injury or other trau Nottingham, MD 21236 ervine Date 20c. Location 20a. Method of Disposition Pages 1 1 → Burial 2 □ Cremation 3 □ Removal from State -15-2007 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice reene Funeral Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto, MD 2122 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOPULMONARY ARREST /Medical Due to (or as a consequence of): **Examiner** ACCIDENT! CEREBROVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 1 Yes 21/2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 2 No 1 Yes Medical Certification: To this 27. May er of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury I hours after death.

**Inneral Director: After the further of the 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) PI ce of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours at To the Funeral Completely filled it 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month Day, Year) 29b. Signature and title of certifier lano NJO D0061480 asmun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4920 completi Blvd Balt, MO'21236 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 16, Bernadine N. Gordon August 2007 1500 р /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 12, 1918 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🖫 F 316-09-9990 89 Indiana Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at MD Harford Bel Air 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1532 Cedarwood Drive 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by white Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Lynn Mitchell Esther Snouffer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra 1532 Cedarwood Drive, Bel Air, MD Susan Lars Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐Removal from State 8/22/07 Prairie Grove Cem. Ft. Wayne, Indiana 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6415 Belair Road, Baltimore, MD 21. Signature of Funeral Service Licensee MCO804 23 Part. Enter the disease, or complet tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ELECTRO MECHANICAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine MUCHADIAL INFALCTION Due to (or as a consequence of): TINFECTION Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an I or Attending Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 1 🗌 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation within 24 hours and to the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2007 30-Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE, SUITE 21/2B, BELAIR, MD 21014

Registrar

State

31. Date filed (Month, Day, Year)

AUG

00

39339 Baltimore, №

Box 68760

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Records,

Division or Vital

32. Registrar's Signature

			Please T				ndelible Ink.				•	
			1 - For State Registrar	State of Ma	arylan	-	ertificate of		/lental Hy	•	-	
		-	Registrar 1. Decedent's Name (First, Middle, Last)				intille ate of		2. Date of D	Reg. No eath).	3. Time of Death
	Physicia /Medic		Vernon Hooker						August	t 19	2007	8:05 a ^M
	Examin		4a. Facility Name (If not institution, give s					r Location of Death		40	. County of Dea	
4		ja e	5905 Franklin Ave		a (In una I	n at hirthda	Gwynn (Uak If Under 24 Hrs.	8. Date of Bi	rth	Baltimo	
	Funeral Director		5. Social Security Number 6. Sex 129	M 2□F	74	a <i>st birthd</i> ay Yrs.	Months Days	Hours Min.	OCT 26	ay, Year)) C	rthplace (State or Foreign ountry) cyland
			Usual Residence of Decedent		7 -+				001 20	J 17.	oz ria.	Lytand
	ryland how		10a. State 10b. County		10c. City	, Town or L	ocation					10d. Inside City Limits
	e Ma Ba-f s otifiec	cto	MD Baltimo	re	Gw	ynn 0						1 □ Yes 2 💆 No
	with th	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What C	ountry?
	eath v	eral	5905 Franklin Ave	nue 12. Was Decedent I	Ever in U.	S 13	21207	lisnanic Origin? (St	necify Yes or N	0-	USA 14. Race - Am	erican Indian.
_	fter d r item ilner	Fun	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ N		.	. Was Decedent of H If Yes, specify Cuba		Rican, etc.)		Black, Whi	
2-003e	ours a ral", o Exarr	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	Korea	a	1 ☐ Yes 2 🔀 No	Specify:			Specify: B.	lack
ဂ ဂ	72 hc 'natu dical	etec	15. Decedent's Educ (Specify only highest grade			16a. Dec (Giv	edent's Usual Occup re kind of work done DO NOT use retired	ation during most of wor	king	16b. K	(ind of Business	/Industry
7	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. In marked other than "natural", or items 23a or 28a-f show martic event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		houseman	a)		Cor	nstruct	i on
ם ס	should be filed withir nd Mental Hygiene. marked other than imatic event, the Ma	ပိ	17. Father's Name (First, Middle, Last)					18. Mother's Nam	ne (First, Middle			
yland	fental fental rked ric ev	To Be	Thomas Hooker					Mary	Valent	ine		
_	0 0 0		19a. Informant's Name/Relationship (Typ	pe. Print)		19b. Mai	ling Address (Street	and Number or Ru	ral Route Numi	ber, City	or Town, State,	Zip Code)
, <u>Z</u>	1 and 2 Health tem 27		Carla Hooker - da	ughter	Tool 5		Franklin					207
0	ges 1 If of H If ite or otl		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ R	emoval from State			oosition (Name of ematory or other place		Date		ocation - City o	
Daltimo	it. Pa intmer intant: injuny		4 Donation 5 Other (Specify)	10	Me		rematory,			1	ltimore	,
מ	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service License Steven	H. Willia	ams		22. Name and Addre Cremati 299 Fre	on Societ	y of Ma	aryla	and, Inc	21228
П			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused	the death						ore, in	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Arteno		noti	e Cardi	ovascu	Jan	Sea	Se	Onset and Death
	/Medical		resulting in death)	Due to (or as		uence of):		000000				
	Examiner	_	Sequentially list conditions,	. — Due to (or as	a consequ	ience of):						
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injuried oversity)	Due to (of do	a consequ	action oi).						
ה	execuin and ial-tra	Exa	that initiated events cresulting in death) Last	Due to (or as	a consequ	uence of):						
00/00	w requires that the death certificate be executed to been signed by the attending physician and should be detached for use as the burial-transit	ical	C d									
	ertifica ing ph e as t	Physician/Medica	IF FEMALE:		,							
OO	attend attend for us	ian/	in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	□Ectopic pregnanc	у			23d. Date of de Month	elivery Day Year
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown	time or di							
r.	The law requires that the ate has been signed by the bage 2 should be detache	by Pr	Part II. Other significant conditions con	tributing to death b	ut not resu	ulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
coras	en sig	ed b	Carcinoma o	+ Lung	,				1 🗆	Yes 2	2 □ No 3 □ F	Probably 4 Unknown
S S	law ru as be	plet	020- Pharygeal	Carcin	omo	١			24a. Wa	opsy	prior to	autopsy findings available completion of cause of
	: The cate h	Completed							per 1□ Yes	formed? 2 X No	death? o 1 ☐ Ye	2.1
VIE 2	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:			ont 30 DOA Oth	26. Place of Dea				
ö	Phys er this eral dii	: To	12 Yes 2 No 127. Manner of Death	28a. Date of Inju	ry	ER/Outpati 28b. Time	of 28c. Inju	4 □ Nursing H	ome 5 Res 28d. Describe		6 □Other (Sp	ecify)
<u> </u>	Attending r death. ector: After by the fune	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury		rk? Yes 2∐No				
UNISION	r Atte er dea irecto	27. Manner of Death 1 Matural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 5 Suicide 6 Could not be determined 5 Suicide 6 Suicide, see S										Rural Route Number,
ב	oital ours after aral Dilled ir	of the disconnection of the di										
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filed in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying Phys (Check only one) Medical Examin		f examina							
	Fo the Within Fo the	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Da	ate signed (Mor	nth, Day, Year)
}	~		1 Hartette MM	Der C	ut		018	6667		Augi	IST ZO	7,2007
j	+1	(30. Name and address of person who co	mpleted cause of d	eath (Iten	23а) (Тур	e, Print)	-, 11	1.1	7	12 0	1002
/	Sta	to	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	nりle ture	24:116	I. Luthe	nu. 11e	1	10 2	1043
	Registr			007	ideal	1.	parti)					

07-06370 Kavin F Hill

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			tificate of Death	Reg. No.	1 6 1 1					
Physici		1. Decedent's Name (First, Middle,Last) Kavin Stanley Hil		2. Date of Death	3. Time of Death					
Medical Exam	iner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	August 17, 2007	2006 hrs					
		Johns Hopkins Hospital	Baltimore	N/A						
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. la: 220 06 4448 1 x 2 F 36	st birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	Forei						
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, 7	Fown or Location		10d. Inside City Limits					
X	'n	MD N/A	BALTIMORE		1 Xyes 2 No					
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f sho atte event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 2810 ASHLAND AVE.	10f. Zip Code 21205	10g. Citizen of What Cou	intry?					
	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - Ame White, etc.	rican Indian, Black,					
urs afte tural",	d by	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kind of w		ACK					
6 : 72 ho an "na cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retir							
OO3	отр	2 years	WAREHOUSEMAN	PLUMBING	SUPPLY					
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Be C	CALVIN S. HILL		(First, Middle, Maiden Surname) LINE HARTWILL						
2 21 should 1 is man atic eve	ြ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or R	tural Route Number, City or Town, State						
≥ bd 2 alth alth a 2 aum		KAREN SYRIA-HILL (wife) 20a. Method of Disposition 120b. Pl	2810 ASHLAND AVE. ace of Disposition (Name of cemetery,	BALTO, MD. 212 Date 20c. Location - City of						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		1 Burial 2 X Cremation 3 Removal from State	ematory or other place) AUG. 2	7,2007						
Baltimore permit. Pages 1 Department of F Important: If i		4 Donation 5 Other Specify: GRI	EEN MOUNT CREMATORY 22. Name and Address of Facility CALVIN B. SCRUG							
		Elmadine l'Arriga	11412 E. PRESTON	ST. BALTO, MD.	21213					
Physician /Medical	8 99	23a. Part I. Enter the disease, or complications that caused the death. I failure. List only one cause on each line.		respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death					
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Congenital Heart Diseas Due to (or as a consequence of):			Death					
	7	Sequentially list conditions, if any, leading to immediate b Due to (or as a consequence of):								
	miner	(Disease or injury that initiated			-					
cuted of transit	Exa	events resulting in death) Last Due to (or as a consequence of): d.								
× = =	Medical	UNPENDED X AMENDED #1, perME, 9870, 8	3/21/∩7 TT							
8 g al		IF FEMALE: 23c. If yes, outcome of pregna	ancy	23d. Date of deliver						
Box 687 death certification at the attending of for use as the	sician/	past 12 months?	2 Fetal death 3 Ectopic pregnar th 5 Other (Specify)	ncy Month	Day Year					
J. Boy t the deatl by the att	Phys	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not res		102- Pillin						
P.(þ	Tark is other significant conditions contributing to death but not res	uiting in the underlying cause given in Part i.	23e. Did tobacco use contribute to	the cause of death? Dably 4 ✔ Unknown					
of Vital Records, by Physician: The law require ther this certificate has been si neral director, page 2 should t	Completed			autopsy prior to	topsy findings available completion of cause of					
tal Rec cian: The la certificate h	S			performed? death? 1 Yes 2 ✓ No 1 Yes	es 2 No					
ital sician: is certif	BB	25. Was case referred to medical examiner? 1 ✓ Ves 2 No. Hospital: Inpatient 2 ✓ E	26.Place of Death (Check of R/Outpatient 3 DOA Other Mursing							
of V ing Phy: After thi uneral d	٤	1 V Yes 2 No Impatient 2 V L 27. Manner of Death 28a. Date of Injury 2		Home 5 Residence 6 Othe 28d. Describe how injury occurred	r:					
ion Itendir leath. for: A	ation	1 V Natural 5 Pending (Month, Day,Year) 2 Accident Investigation								
Division pital or Attendi ours after death. eral Director: /	Certification:	3 Suicide 6 Could not be determined (Specific) (Specific)								
lospita 4 hours umeral										
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the i	(Check only one) (Check one) (Che									
FSFS	and manner stated. 29b. Signature and title of certifier 29c. License number Come 29d. Date signed (Month,									
		Theodor M. Kig The	O.C.M.E.	August 21, 2007						
\		30. Name and address of person who completed cause of death (Item 2: Theodore M. King, Jr., MD. Assistant Medical Ex	•	MD 21201						
	ate	31. Date filed (Month, Pay Year) 1 32. Registrar's Signature								
Regist	rar	AUG Z I ZUUT PROGRAM L	1 Apoles							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 Alice Mae Humphreys /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Health and If Under 24 Hrs. Social Security Number **Funeral** Year Months 1 □ M 2 □ **X** Hours 18,1919 213-16-8525 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f sh notified 1 ☐ Yes ŽX No Director Maryland | Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hyglene. Important: If item 27 is marked other than "--- any injury or other traumation." 21050 2545 Johnson Mill Road USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. I ∏Yes 2 XNo f Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify. Specify: 3 ₩idowed 4 Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Callege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Violet Ellen Redden Amos (NMN) Cox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2545 Johnson Mill Road, Forest Hill, Maryland 21050 Dane T. Humphreys/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rockawalkin U.M. Chr08-17-2007 Hebron, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MCC mas Fune 1317 Cokesbury Road, Abingdo 23a. Part I. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each 22. Name and Address of Facility McComas Funeral nome, P.A., 1317 Cokesbury Road, Abingdon, Maryland, 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** YPUV 1 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Examiner that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 25 No 9 Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ≥ No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of eath 28a. Date of Injury 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

within 24 hours aft

To the Funeral Di

completely filled in

DHMH 17 Rev 1/2001

State Registrar 50011

2 North

D34652

30. Name and address of person who comple ed cause of death (Item 23a) (Type, Print)

Avince Bel Air Mary land 210N

32. Registrar's Signature 31. Date filed (Month, Day,

			For State	State of	Marylar		artment of H		, ,			
			Registrar 1. Decedent's Name (First, Middle)	e, Last)			Timodio or E	Journ	2. Date of Dea	Reg. No.		3. Time of Death
	Physici		Felton	LeVan		Hill			Month August	Day	Year 2007	11:56 a ^M
1	/Medic Examin		4a. Facility Name (If not institution		iber)		4b. City, Town, or	Location of Death	7.agaoo		County of Death	11130 0
	LAGIIII	*	Washington Adventis	t Hospital			Takoma F	Park		Mo	ntgomery	
	Funeral		5. Social Security Number		7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birthp	place (State or Foreign
	Director		579-50-3311	1 ⊠ M 2□F	68	Yrs.	monute Days		June 6,			Carolina
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation	-			1.	10d. Inside City Limits
	with the Maryland a or 28a-f show the notified at	ō	Maryland Prince			aurel						1 X Yes 2 □ No
	the N 28a-	Director	10e. Street and Number	deor ges		.aurer	10f. Zip Code			10a. Citiz	en of What Cou	ntry?
	aa or		9009 A Contee Road				20708	}		U.S.	Δ	
	death ms 2,	Funeral	11. Marital Status	12. Was Dece		.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-		14. Race - Americ	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	2 ⊠ No e		If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	In, Mexican, Puerto Specify:	Hican, etc.)		Black, White, Specify: B1 a	
2-0	72 ho natur lical	Completed	15. Deceden	t's Education st grade completed)			dent's Usual Occupa		ina	16b. Kin	nd of Business/In	dustry
21	within ene.	n ple	Elementary/Secondary (0-12)	College (1-	-4or 5+)	life.	DO NOT use retired,)	9			
2	filed w Hygier ther th		11	4 0		School	1 Bus Drive		- (Final Adial-U-		rd of Educ	ation
and	be fil	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Name	e (FIIST, MIDDIE,	Malden S	Surname)	
Z	should be and Mental s marked o	2	William Franklin Hi 19a, Informant's Name/Relations			10b Maili	ng Address (Street a	Lillie Mae		e City or	Taum Ctato Ti	Code
Ma			April Hill / Davaha				le lody Ave				rown, State, 21,	Code)
	es 1 and 2 should b of Health and Ment item 27 Is marked r other traumatic e		20a. Method of Disposition		20b. i	Place of Dispo	sition (Name of	1 1	Date		cation - City or To	own, State
Baltimore,	permit. Pages: Department of I Important: If ite any injury or of		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation Я ☐ Other (S		state	tro Crem tro Crem	matory or other plac natory	8/15/2	2007	Cator	nsville, M	laryland
a E	mit. I partm portal rinju		21. Signature of Fineral Service			22	2. Name and Addres	ss of Facility				20.0
ñ	an III		1/min	E well.		FI	eck Funeral	Home 7601	I Sandy Sp	oring	Road LAur	el Maryland
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that ca only one cause on ea	aused II e deat ach line.	th. Do not ent	er the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Sel	leco	OMES	2				Onset and Death
	/Medical Examiner		resulting in death)	Due to (c	or as a cons	e of):	W 1.00	4				
	LAMINING	<u>.</u>	Sequentially list conditions,	b. — Due to (or as a consec	uanos of						
$\overline{}$	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (t	or as a consec	querice or).						
	cate be executed physician and the burial-transit	Examine	that initiated events resulting in death) Last	C. Due to (c	or as a consec	quence of):						
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9	ifficat g phy as the	ledic		u			*					
Вох	leath certific attending p I for use as 1	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come pf pregn irth 2 □ Feta		Ectopic pregnancy			2	3d. Date of deliv	
	deat e att	Sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of o		Other (specify)				Month	Day Year
P.0	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/Me	9 □Unknown			111.0			00 0:11			1 1 1 1 1 1 1
	res the signed	by	Part II. Other Significant/condition	ons contributing to de	ath but not res		nderlying cause give	эп іп Рап І.	23e. Did to		se commute to t ∃No 3 ⊟ Prol	he cause of death?
O.C	w requir been si should I	ted	Creadi	M III	un (N n				L,	Dably 4 John How
3ec	g 8 6	Completed							24a. Was autop	sy	24b. Were auto prior to co death?	ppsy findings available impletion of cause of
or Vital Records,				. 1					1□ Yes	2 No	1 ☐ Yes	2 1 10
<u>Ş</u>		o Be	25. Was case referred to medica examiner? 1 ☐ Yes 3☐ No	Hoenital:	patient 2	EP/Outpotion	nt 3 DOA Othe	26. Place of Deatler:				
	y Physer this eral di		27. Manner of Deut	28a. Date o	of Injury	28b. Time o			28d. Describe h		☐Other (Special occurred	<u> </u>
ion	vttending F death. ctor: After y the funera	atio	1 2 Pendir 2 Accident investi	ig .	h, Day Year)	Injury		Yes 2 □ No				
Division	Attender death rector:	Certification:	3 Suicide 6 Could 4 Homicide determ	inad Zoe, Flace	of injury - At h	ome, farm, str	eet, factory, office		28f. Location (S City or Tow			al Route Number,
ō	ital or rs afte ral Dir									.,,		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ledical		ng Physician: To the Examiner: On the ba	asis of examina							
	To the within 24	Med	29b. Signature and title of certifie	and mann	or stated.		29c. License	e_number ,		29d. Date	e signed (Month,	Day, Year)
1	FSFŏ			~			\(\sigma\)	614	7	8	17/	7
1	7		30. Name and address of person	who completed cause	e of death (Iter	m 23a) (Type,	Print)	, – (1		1 / 10	/
)			Dpinder X. Singh	7600 Car	rol Avon	uo Tako	ma Dank M	Maryland 20	0912	- 1	1	
	Sta		31. Date filed (Month, Day, Year)	32.	egistrar's Sign	ature	and I					
	Registi	4, 5	AUG 2	1 2007	aluse .	N 19						
DH	MH 17 Rev 1/2	001										

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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OYIJE IHEAGWARA 3001 S. HANIOVER STREET, BALITIMORE, MD 2122

32. Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar Amend Items	State of Mar 24a,27 pe	yland / De r dr.,g8	partment of H 70::/\dags.21 /19	lealth and N Teat h	lental Hygle _{Reg.}	ne No. 2 (1 1) 7	25773
à			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al	AMOREL		IENRY			08	7 2007	
	Examin	er	4a. Facility Name (If not institution, give s Levindale Hebrew		Center	4b. City, Town, or Baltim	Location of Death		4c. County of Death	
			5. Social Security Number 6. Sex		(In yrs. last birthda		If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Funeral Director			M 2007F	91 Yrs	Months Davs	Hours Min.	July 7, 1	ear) Cou	intry) ecticut
*			Usual Residence of Decedent				1			40d Leide Oit Limite
	show	_	10a. State 10b. County		l0c. City, Town or					10d. Inside City Limits 1 ☐ Yes 21 No
	ne Ma 8a-f s	Director	MD Baltimor	e	Balti	more		100	. Citizen of What Cou	
	should be filed within 72 hours after death with the Maryland of Mental Hyglene. In marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than Medical Examiner must be notifiled at		10e. Street and Number 610 Marwood Road				L204	109.	USA	
	leath ns 23 must	Funeral		2. Was Decedent Ev	rer in U.S. 1	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	
တ	after o		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:	rican, etc.)	Black, White	nite
9	urai",	d by	3 MWidowed 4 Divorced	Year or Dates:		-		40		- Total
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12	withir ene. than he Me		Elementary/Secondary (0-12)	College (1-4or 5+)	'	secretary	-7			
Maryland 21215-0036	Hiled Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma		
lan	Jid be Jenta rked tic ev	10 B	Monroe Whitney Tu	ttle			Laura P	eirce Bla	nchard	
ary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Typ	*		ailing Address (Street				
	es 1 and 2 should to of Health and Ment Fitem 27 is marked rother traumatice		Levindale Hebrew G	eriatric (34 W. Belve			more MD 2	21215
altimore,	Pages 1 nent of H int: If Itel iry or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery,	sposition (Name of crematory or other plac	ce)	Date 20	c. Location - City or	Own, State
Balt	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service License Ronald S. V	ade, Dire	ctor	22. Name and Addre State Anat Baltimore.	omy Board		Baltimore	Street
	0-300		a. Part . Enter the dise e, or compleshood or heart failure. List only or	cations that caused to					i,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	TERM		DEMEN				Onset and Death
1	/Medical		resulting in death)	Due to (or as a	consequence of):					
L.	Examiner	_	Sequentially list conditions,)	nonnoquenco of\:					
- 3	pe:	ine	Sequentially list conditions, if any, leading to immediate cause. Lines for linder, in Cause (Disease or injury that initiated events	Due to (or as a	consequence of):					
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
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ဖ	tificat ig phy as the	0.0								
ŏ	res that the death certifii igned by the attending Is be detached for use as	Physician/M	23b. was decedent pregnant	3c. If yes, outcome p 1□Live birth 2		3 ☐Ectopic pregnanc	y		23d. Date of deli Month	ivery Day Year
E	e dea he att	sici	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No	4☐Pregnant at t 9☐Unknown		5 ☐ Other (specify) _			Worth	Day
<u>م</u>	d by t letach	Phy	9 ☐ Unknown Part II. Other significant conditions con	ntributing to death but	not resulting in th	e underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Division or Vital Records, P.O. Box	signe signe	by	Tarrii odior olgimiodii oonaliolo oo	g		, · · g - · · · · g		1 ☐ Yes	2 No 3 Pr	obably 4.Hunknown
Š	w require been signature	Completed						24a. Was an	24b. Were au	topsy findings available
Re	he lav e has ige 2 :	gu						autopsy performe	prior to death? XNo 1 \(\text{Yes} \)	topsy findings available completion of cause of 2 ☐ No
ta	ysician: The is certificate hadirector, page		25. Was case referred to medical				26. Place of Dea	1 Yes 2 into the Check onlone	VIAO I ITT 162	2010
<u> </u>	Physici this cer al direct	To Be	examiner? 1 ☐ Yes 22 No	lospital: 1 ☐ Inpatien	t 2 ER/Outpa	atient 3 DOA Oth	ner: 4 Nursing H	ome 5 Residen	ce 6 □Other (Spe	cify)
0 0	ng Ph fter th neral		27. Manner of Death 1 XNatural 5 □ Pending	28a. Date of Injury (Month, Day			ry at rk?	28d. Describe how	injury occurred	
Sio	tendii eath. tor: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No	OOS I reading (Chro	et and Number or Ru	um l Pouto Number
Ž	or At ifter d Direct in by	Certification:	4 Homicide determined	building, etc.	y - At nome, farm (Specify)	, street, factory, office		City or Town,	State)	nai noute number,
	spital		29a. Certifier 1 Certifying Phy	sician: To the best of	f my knowledge, o	leath occurred at the t	ime, date and place	, and due to the cau	ise(s) and manner as	stated.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical Exami one)	ner: On the basis of and manner stat	examination and/	or investigation, in my	opinion, death occu	rred at the time, dat	te and place, and due	to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier			29c. Licens			d. Date signed (Mont	
	,		Barra P	MYSICIAN	٥	1>00	064533		08.07	- 200+
	0		30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (Ty	pe, Print) LEVIT	SALE HE	BREW GE	RIATRIC C	CNIER
	(~		BABATUNDE M- 31. Date filed (Month, Day, Year)	AJANI 32 Registra	r's Signature	~734 W	DELVER	GLE AVE	BALTIMO	RE MJ 21215
	್ಲಿ Sta Regist		AUG 2 1 2007	AJANI 32. Registra	y for	te				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02:14 PM Physician AUGUST Holloway Jethro 2a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** Months Days 1√ M 2□ F 41 251-25-5456 Director 5-28-1966 S.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Tyes 2 □ No Director Baltimore NA Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21218 1622 Abbotston Street Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Married Married altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: Black X 3 ☐ Widowed 4 ☐ Divorced þ Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mid-Atlantic Regional if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Council of Carpenters Carpenter NA 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Christine Holloway Gus ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 725 Coggeshall Rd., Darlington, S.C. 29532 Mother Christine Holloway 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 Bunal 2 □ Cremation 3 □ Removal from State 8-25-07 Darlington, S.C. Family Plot 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 anes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical attending pt for use as tl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for g Unknown g □ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy 1☐ Yes the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA Medical Certification: To this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manne of Death 1 Natural After (Month, Day Year) Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. ours after death.

neral Director: #
filled in by the for 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide within 24 hours at To the Funeral Completely filled 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifier bun , MD AT 2438946 AUGUST 19, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STYAM, M.D. UNION MEMORIAL HOSPITAL, MD AMIRA MOHAMMED 31. Date filed (Month, Day, Year) State AUG 2 1 Registrar 2007 Billian .

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滩	Physici	on	1. Decedent's Name (First,	Middle, La	st)							2. Date of Do	D	ay Yea	r	3. Time of	Death
*	/Medic		Irene H.L.									August	18	2007		8:47	Ам
	Examin	er	4a. Facility Name (If not inst			oer)			ty, Town, o		of Death		4	c. County of De	eath		
			10702 Gains	borot		A = 0 // = 1 = 1	look birth door		otoma der 1 Year		04 Um	1 0 B-t(B)	-41	Montgo			
5	Funeral Director		5. Social Security Number 353-30-0767	_ 1	Sex I□M 2XTF	. Age (in yis	. last birthday, Yrs.	Month		Hours	Min.	8. Date of Bi (Month, Di February	av, Yea	1927	Birthpla Countr	ce (State or Chir	r Foreign 1a
	pur *		Usual Residence of Deceder 10a. State 10b. C			10c. C	ity, Town or L	ocation							100	d. Inside Cit	by Limite
	/ary। sho	ō		,	omery		•								100	1 ☐ Yes	•
	the N 28a-	Directo	10e. Street and Number	onego	Jiliely		Potom	_	Zip Code				10a C	itizen of What	Countr	v?	
	Mith 3a or st be	Ö	10702 Gains	boroi	igh Road				20854				_	Jnited S			
	ms 2	Funeral	11. Mantal Status		12. Was Deced	ent Ever in l	J.S. 13.				igin? (Sp	ecify Yes or No Rican, etc.)		14. Race - Ar	nericar	n Indian,	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Meifical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ½ 3 ☐ Widowed 4 ☐ Div		Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Dat	No No			pecify Cuba 2 🛣 No	an, Mexica <i>Sp</i> ec <i>ify</i> .		Hican, etc.)		Black, Wi			
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ē,	f Hea		20a. Method of Disposition	nuspa	1114	20b.	Place of Dispe	osition (A	lame of			Date 19,	T	Location - City			
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Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Se				Re Re	2. Name obert	and Addre	ss of Facili	Tune:	ral Home,	/Beth	esda-Che	vy Cl	hase, I	
	-		23a. Part1. Enter the disea	se, or com	plications that car	MO1 used the dea								yland 208	1	Approximate	9
	Physician		shock, or heart failure Immediate Cause (Final	List only			1 T - C									Interval Betw Onset and D	
7	/Medical		disease or condition resulting in death)	-		ardia as a conse	1 Infa	rcti	on						+-		
н	Examiner		0	- 1	Arte	eriosc	leroti	с Не	art D	iseas	e						
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87	physi the I	Medical			_ d										+		
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\mathbf{m}	The law requires that the death oe the has been signed by the attendir bage 2 should be detached for use	Physician/	23b. Was decedent pregna in the past 12 months' 1 □ Yes 2 ☒ No		1 ☐Live bir	th 2 □ Fet nt at time of	al death 3[pregnancy (specify)			Month			/ear			
P.O.	the cy the achec	hysi	9 Unknown		9□Unknov	'n											
ري ت	res that the de signed by the a be detached f	by P	Part II. Other significant co	n ditions o	contributing to dea	th but not re	sulting in the u	ınderlyinç	g cause giv	en in Part I	l.	23e. Did tobacco use contribute to the cause of					eath?
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n C	ing F After funera	P 0 1 07 14							28c. Injur Worl			28d. Describe	how inj	ury occurred			
Division or	27. Manner of Death 1 Natural 2 Accident investigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Place of injury - At home, building, etc. (Specify)							M reet fact		Yes 2□	-	28f Location /	(Stroot	and Number or	Durall	Douto Numi	har
<u>></u>									ory, onice		- 1	City or To	wn, Sta	and Number or te)	riurau r	HOUSE IVUING	jer,
									ed at the tir	ne, date ar	nd place.	and due to the	cause	s) and manner	as stat	ted.	
	ne Ho n 24 h ne Fui	Medical	(Check only 2 ☐ Me one)	dical Exar	miner: On the bas and manne	is of examin	ation and/or ir	vestigati	ion, in my o	pinion, de	ath occur	red at the time	, date a	nd place, and d	ue to t	he cause(s))
	To the within 2 To the соттре	Me	29b. Signature and title of c	-				2	29c. License	e number			29d. D	ate signed (Mo	nth, Da	ay, Year)	
	a		Daler	Hal	Rick 2	70			D28	426			Aug	ust 18,	20	007	
6	7		30. Name and address of pe	rson who	completed cause	of death (Ite	m 23a) (Type,	Print)				-					
	l		Galen Hallic					oad,	#100	, Bet	hesd	a, Mary	y1an	d 20817	-11	.83	
	Sta		31. Date filed (Month, Day,	Year)		trar's Sign	ature	loves	Es.								

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Jugus Year **Physician** RENE HORTON 2007 12.55AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 24 Hrs. re VINGION Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 9. Birthplace (State or Foreign (Mary (and If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 M 2 € 218-22-8975 Usual Residence of Decedent Yrs. Director death with the Maryland 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 28e-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ö 16 or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced lack naturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) ome Maker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) rmit. Pages 1 and 2 should ba filt partment of Health and Mental Hy portant: If item 27 Is marked oth y injury or other traumatic even ona 19b. Newton Address (Street and Number of Fural Figure Number City or Town, State, Zip Code) 19a Mikita Horton (grandiaughter) MS. NIKITA Baltimore, 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State Green Mount Crematory 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. 9/11/2007 Baltimore, Mc . Signature of Funeral Service, Licenses 22. Name and Address of Facility
Toseph Li Russ Funeral Home P.A.
2222W. North Ave Bauto, Md. 21216 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carcin **Physician** ongu /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Certification: To Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy or in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the Division of Vital Records, P.O. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 🖫 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2 No 1 Yes 2 X No or Attending Physicien: ours after death.

Interest Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide Hospital within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number HYSICI AN 575 75 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE BALTIMORE SANDHU 940 57. W. strar's Signature 31. Date tiled (Month, Day, Year) 32. Re State AUG 2 2007 Registrar

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07-00200	

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Dai	rius Vaughan		State of Maryland		of Health and			* E	07 2677	
Me	Physicia dical Exami	an/	1. Decedent's Name (First, Middle,Last) Darius Vaughn Hicks				2. Date of Death Month D August 12, 2	ay Year 2007	3. Time of Death 0755 hrs	
7			4a. Facility Name (if not institution, give street and number) Doctors Community Hospital		4b. City, Town, or Lanham	Location of Death		4c. County of D Prince Geo	rge's	
	Funeral Director		577-45-6023 1X _{M 2} F	e (In yrs. last birthday) Yı	If Under 1 Year Months Days		8. Date of Birth(F	Birthplace (State or or or or or or or or or or or or or	
-	daryland 28a-f show any 1 at once.	or	Usual Residence of Decedent 10a. State 10b. County DC	10c. City, Town or Loca Wash	nington				10d. Inside City Limits 1 Yes 2 No	
)	eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Director	10e Street and Number 1324 Mapleview Place SE		10f. Zip Code 2002	Citizen of What Country?				
	s after death with ral", or items 2: iner must be n	by Funeral	3 Widowed 4 Divorced If Yes, Give Year or Dates:	X No	Vas Decedent of His Yes, specify Cuban Yes 2 X No	specify:	Rican, etc.)	White, e	Black	
	D 21215-0036 should be filed within 72 hours after death and Montal Hygiene. 7 is marked other than "natural", or iten after event, the Medical Examiner must.	Completed	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12) College (1-4 or 9)	5+) during	ent's Usual Occupat most of working life. None	. DO NOT use reti	red)	6b. Kind of Busin	ess/Industry	
	MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. 10 7 is marked other than annatic event, the Medica	Be	17. Father's Name (First, Middle, Last) Donnell Hicks	Lie			a D. Tol	son		
	Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ex	To	19a. Informant's Name/Relationship (Type, Print) Donnell Hicks/Father 20a. Method of Disposition		ing Address (Stree Maplevie osition (Name of cer	ew P1 SE	Washingt		20020	
	timore it. Pages 1 rtment of H rtant: If it		1 X Burial 2 Cremation 3 Removal from Sta 4 Donation 5 Other Specify: 21. Sign and 5 Peral Serve Licensee	Ft. Lin	other place) ncoln Ceme . Name and Address				od, Maryland	
,	Physician Physician		23a. Part I. Enter the disease, or complications that caused	545	7474 Land	dover Roa	d Landov	er,Mary	and 20785	
	/Medical Examiner	1	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a const	qlained death		11.			Between Onset and Death	
	,	ansit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	equence of):						
	uted nd ransit		(Disease or injury that initiated events resulting in death) Last C. Due to (or as a const.) d.	equence of):						
	60, ate be executed hysician and e burial - transit	Medical	X UNPENDED #23a,27,28c	a-f.perME.g871	1,9/19/07 T	Γ		23d. Date of de	livery	
	Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. After this certificate has been signed by the attending physician and appletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	2 F	Fetal death 3 Other (Specify)	Ectopic pregna	ancy	Month	Day Year	
	cords, P.O. B aw requires that the de nas been signed by the 2 should be detached it	by	Part II. Other significant conditions contributing to deat	h but not resulting in the	e underlying cause ç	given in Part I.	parameter		te to the cause of death? Probably 4 Unknown	
(2)	of Vital Records, ag Physician: The law requiranter this certificate has been sineral director, page 2 should b	ompleted					24a. Was an autopsy perform 1 ✓ Yes 2	prio	re autopsy findings available r to completion of cause of th? Yes 2 No	
de la	tal F cian: Certific ector, p	Be C	25. Was case referred to medical examiner? Hospital:			Other				
E,	n of Vital B fing Physicians L. After this certifi funeral director,	္	1 Ves 2 No Inpatie 1 Inpatie 27. Manner of Death 28a. Date of Inju	ent 2 ✓ ER/Outpatie	ant o Don't				Other:	
H 1- Wanne (widale	Division of tall or Attending and or Attending are after death. ral Director: Aft lied in by the func	Certification:	1 Natural 5 Pending Fnd 8/12, Accident Investigation	Find 8/12/2007 FNd 6:58 am 1 Yes 2 X No			28d. Describe how injury occurred unk 28f. Location (Street and Number or Rural Route Number, City			
7-	Divisi spital or Att tours after do neral Direct	Certifi	3 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) (Specify) found at residence 28f. Location (Street and Number or Rural Roor Town, State) 6110 Box Oak Ct. Lanham, N							
dhe	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner: On the basis of examiner stated.		gation, in my opinion	n, death occurred a	at the time, date ar	nd place, and due	to the cause(s)	
		Σ	29b. Signature and title of certifier		29c. Licens			August 13, 2	(Month, Day, Year)	
0	OCME		30. Name and addless of person who completed cause of a Mary G. Repple MD. Deputy Chief Medi	cal Examiner 1	11 Penn Street	t, Baltimore, M	1D 21201			
	S	tate	31. Date filed (Month, Day Year) 32. Resetra	r's Signature	1					

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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Calvin

2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 9:00 AM 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALTIMORE NURSING FREHAB, CENTER NLA If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) NOV, 27, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2ÀF Months Days Min 219-18-8109 Usual Residence of Decedent Director 10d. Inside City Limits 10b. County 10c. City, Town or Location show ns 23a or 28a-f shormust be notified at 1 Yes 2 No Director MARULAND 10a. Citizen of What Country? 10e. Street and Number Funeral 14. Race - American Indian, Black, White, etc. ral", or items 2 Examiner mu Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: þ 3 Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WORKER RIVATE FAMILIES 7 Is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (ျှ 19b. Mailing Address (Street and Number or Rural Foute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a PATRICIA other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5 1X Burial 2 □ Cremation ROWNSVILLE Important: I any injury o once. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee -ULTON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Discore Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 ☑Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ★ No autopsy perform 1∐ Yes 2 Alo the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

| Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN 57543

34

State Registrar AUG 2 1 2007

- SANDHU, MD 1940 IW.
Date filled (Month, Day, Year) 2. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1940 IN. BALTIMORE ST, BALTIMORE, M 02/223
32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and M State of Maryland / Department of Health and M Certificate of Death	lental Hygier	EL O V	2578)
	Physici /Medi		1. Decedent's Name (First, Middle, Last) James Whysen	2. Date of Death Month	Pay 2007	3. Time of Death 10:30 AM
	Examir Funeral	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HOSPITAL 5. Social Security Number 6. Sexy 7. Age (In yrs. last birthday) 10 M 20 F 7 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Gounty of Death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	DYC lace (State or Foreign
	Director		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	01.83.1	450 /U ·	Od. Inside City Limits
	with the Maryland a or 28e-f ehow	rector	mD Baltimore Perry Hall 106. Street and Number 107. Zip Code	10g. C	Citizen of What Coun	1 □ Yes 2 No
Sign	er death Iteme 23	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Ampel Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto If Yes, Give 1 Yes 2 No Specify:	L	14. Race - Americ Black, White, of Specify: Black	an Indian,
121215.	permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or enty Injury or other traumatic event, tra Medical Examinance.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Life. Decedent's Usual Occupation (Give kind of work done during most of works) (Give kind of work one during most of works) (Give kind of work one during most of works) (Fig. DO NOT use retired) Engineer.	BO	Kind of Business/Inc	dustry
Maryland 2	should be fill and Mental H marked oth	To Be	John T. Johnson Arie Wi			
e, Mai	1 and 2 st Health and tem 27 te n		20a Method of Disposition 20b. Place of Disposition (Name of	erry Hal	Location - City or To	1128
Baltimo	permit. Pages Department of Important: If it eny Injury or o		1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funerat Service Licensee 22. Name and Address of Facility V Cu			
	20799			Mandales		
	Physician and //Medical Examiner	Examlner	tmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			Onset and Death
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Вох	Attending Physician: The law requires that the death certific rotath. r death. ector: After this certificate has been signed by the ettending p by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		23d. Date of delive Month	ry Day Year
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of Vit	Physician: Thysician: This certificer	To Be	examiner? 1 Yes 2 No	me 5 Residence		<i>'</i>)
sion	ittending Ph death. ctor: After thi / the funeral.	Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident Investigation M 1 Yes 2 No	28d. Describe how in		
Div	i di ti	i Certif	4 Homicide building, etc. (Specify)	City or Town, Sta		
	To the Hospital or within 24 hours after To the Funeral Direction completely tilled in	Medicai	29a. Certifier (Check only only) 2□ Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, a 2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title, et certifier 29c. License number	ed at the time, date a	nd place, and due to	the cause(s)
	Viti Con	8/	Date signed (Month, L			
	01		Name and address of person a leted cause of death (Item 23a) (Type, Print) Ur. Debra Huttens 9000 Franklin Sq Drive	Baltin	nore, Ma	1 21137
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature		,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25 M Month JUNIUS Dubus 200 5 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HOSPITHE GENTER RANDA/STOWN 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 1 XM 2 ☐ F Months Days Hours Min 223-28-8868 4-11-1924 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Pikesville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 3718 Parkfield Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married SpecifyAfrican-American 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator 10th Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cora Elise Mallory William McKinley James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3718 Parkfield Rd., Pikesville, MD 21208</u> Essie M. James/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 8-24-07 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wife Fineral Rome P.A. of Palbo. Co. ure of Funeral Service Licenses 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nmediate Cause (Final PREMIONYA Immediate Cause (F disease or condition resulting in death) Due to (or s a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ Ho SE(ZURE Dison 1∐ Yes 2 ... NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 N 1 patient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

ò death with

or items 23a Examiner must

"natural"

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and Mental Hygiene.

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Department of Important: If its any injury or o once.

filed within 72 hours after

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Pages 1 and 2 streent of Health a 27

Baltimore, Maryland 21215-0036

be notified

Director

Funeral

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Completed

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

27. Manner of Death

1 🖪 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

/Medical

MD

burial physician the S.E asn ģ ed by the a signed b has page

Box 68760.

certificate funeral director this After death.

that the death certificate be executed P.O. Records, Vital Physician: Division or or Attending ours after death. neral Director: A filled in by the fu Hospital thin 24 hours a completely 2

31. Date filed (Month, State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

th, Day, Year) AUG 2

5 Pending investigation

6 Could not be determined

32. Resistrar's Signature

and manner stated.

. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Iniury

28c. Injury at Work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1 ☐ Yes 2 ☐ No

Cinter 21/33

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Trust .	į.	-	- 1	ě	J

		1- For State Certificate of Death Registrar		g. No.	,						
Physic		Decedent's Name (First, Middle,Last)	Date of Death Month	Day Year	3. Time of Death						
Medical Exan	niner	SAMUEL JONES 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	August 15,	4c. County of Deatl	1559 hrs						
		Johns Hopkins Hospital Baltimore		N/A							
Funera	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	_	h(MM/DD/YYYY) 9. Bir							
Directo	r	213 70 0916 1X M 2 F 50 Yrs. Months Days Hours Min.	APR.1	1,1957 Foreign	ountry) MD						
· " . " . "		Usual Residence of Decedent			1404 1-24- 02-14-2-						
ow any		10a. State 10b. County 10c. City, Town or Location BALTIMORE CIT	1V		10d. Inside City Limits 1 XYes 2 No						
Maryland or 28a-f show	cto	MD N/A BALTIMORE CIT 10e. Street and Number 10f. Zip Code		g. Citizen of What Cou							
the Ma	ä	1712 POPLAR GROVE ST. 21216		USA	,						
after death with the Maryland al, or items 23a or 28a-f she mark he notified at one	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 17. Never Married 2 Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 15. Was Decedent of Hispanic Origin? (Sp. 17. Never Married 2 Married 2 Married 2 Married 2 Married 14. Was Decedent Ever in U.S.	pecify Yes or No- Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,						
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36 n 72 h nan "r	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	160),								
5-0036 led within 7. Tygiene. other than	E E	12 TH CARPENTER 17. Father's Name (First, Middle, Last) 18.Mother's Name	(First Middle M	SELF EMI	PLOYED						
21215-0036 21215-0036 Mental Hygiene. marked other than	Be C		A HALS								
	P	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F			e, Zip Code)						
AE 2 sl 2 sl 27		BETTY FAULCON (sister) 938 JACK ST. BAL		-							
		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date .	20c. Location - City or							
		4 ponation 5 Other Specify: GreenMount CREMATORY . 2	3,2007	BALTO,	MD.						
Baltimore, permit. Pages I an Department of He Important. If ite		21/Signature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUG 1412 F. PRESTON			Ξ						
Physicia	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	ST B	ALTO, MD	21213 Approximate Interval						
/Medica	1	failure. List only one cause on each line.			Between Onset and Death						
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38760 rtificate ring phys	N/C	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy	23d. Date of deliver Month	y Day Ye ar						
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O. Bo) that the deatl red by the att	P _F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?						
ords, P.O. w requires that the state of the		g		2 No 3 Pro							
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Div ospital or hours afte uneral Dir	5	4 Homicide (Specific Control of C			t. Baltimore, M						
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely Illied in by the funeral director mass 2 should ha deached for mess as	The standard of the standard o										
To To Com	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo							
		Course Holloan O.C.M.E.		August 16, 2007	7						
0		30. Name and address of person who completed cause of death (Item 23a)									
1-1		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	1								
Regi	State strar	31. Date filed (Manth, Day Year) 2007 Registrar's Signature									

OCME

			For State Registrar	State of Ma	aryland	-	artment of F <i>rtificate of</i>		Mental Hy	/giene Reg. No.	1117 03.75	7
F	hysici		Decedent's Name (First, Middle,	Charles	She	phero	Jones		2. Date of De Month	eath Day	3. Time of Death 2007 1:45A	
	/Medio Examin		August						4c. County			
			Longview Nurs					cheste			Carroll County	
Funeral Director		212-30-0324	6. Sex 7. Age 1 7. Age	e (In yrs. la	as <i>t birthday)</i> 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bi (Month, Di	rth a <i>y, Y</i> ea <i>r)</i> I – 1932	9. Birthplace (State or Fore Country) Maryland	ign	
and	T T		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation				10d. Inside City Lim	its
Mary	Maryla a-f shor	ctor	Maryland Car	roll		Ma	ncheste	er			1 □ Yes 🗶	No
with the	Funeral Director	10e. Street and Number Longview Nurs 3332 Main Str	sing Home			10f. Zip Code	21102		10g. Citizen of US	,		
deat	ems 7	ner	11. Marital Status	12. Was Decedent E Armed Forces? ed 1 ☐ Yes ♣️♣↑	Ever in U.S	S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Specify Yes or No	0- 14. Rac	ce - American Indian, ck, White, etc.	
partition of the property of the partition of the partiti	by	1 □ Never Married 2 2 Marrie 3 □ Widowed 4 □ Divorced	ed 1 ☐ Yes 五子 N If Yes, Give Year or Dates:	No		1 □ Yes 2 No		rio i riodi, otori	Specif			
72 hc	'natu dical	etec	15. Decedent' (Specify only highes	(Specify only highest grade completed) . (Give kind of work dans during most of working							Kind of Business/Industry	
d within giene.	than the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		abber wo			20 Yea Schenu	it Tire Co.	
uld be file Mental Hy	irked othe itic event,	To Be (17. Father's Name (<i>First, Middle, L</i> Ellsworth		nes				me (First, Middle Mary Fr		^{ne)} Rudisill	
nd 2 sho	27 is ma er trauma		19a. Informant's Name/Relationsh Eleanor L. Jo			l	ng Address <i>(Street</i>		Rural Route Numb er, Per	-		
Pages 1 a	nt: If item iry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		20b. Pla ce Lake	ace of Disponentery, cre	osition (Name of matory or other pla ew Memor	ce)	Date rk 8/18		- City or Town, State	
permit. Departm	Importa any inju once.		21. Signature of Funeral Service	icensee		2 <u>‡</u>	2. Name and Addre	ess of Facility Ienss-Se	eitz Fu	neral	Home, Inc MD, 21211	
	5773		23a. 1. Enter the diffease, or o shock, or heart failure. List of	comple tions that caused	the death.	. Do not en	ter the mode of dyi	ng, such as cardia	ac or respiratory a		Approximate Interval Between	
Phys	sician		Immediate Cause (Final disease or condition	me ta	sta!	KC	Renal	~ Can	591,		Onset and Death	
	edical miner		resulting in death)	Due to (or as	a consequ	ence of):						
P	ES	ner	Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as	а солведы	enne at):						
icate be executed	an and rial-trans	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequ	ence of):						
ate be	hysicia the bu	lical	1	d								
Sertific	ding p se as		IF FEMALE:	23c. If yes, outcome	nf nregnar	ncv				004 D	and the second	
he death o	been signed by the attending physician and should be detached for use as the burlal-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal	death 3[□Ectopic pregnanc □ Other <i>(specify)</i> _	у		I	ate of delivery onth Day Year	
that t	ned by detac		Part II. Other significant condition	ns contributing to death bu	ut not resul	Iting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use con	tribute to the cause of death?	
equires	been sign	ted by							1 🗆	Yes 2∭No	3 ☐ Probably 4 ☐ Unkno	wn
The law r	ate has be oage 2 sh	Completed							24a. Was auto perf 1∏ Yes	opsy ormed2	Were autopsy findings availa prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	ole of
Slan:	ertifica ctor, p	Be C	25. Was case referred to medical examiner?					26. Place of De	eath (Check only			
hysic -	this coal dire	은	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie		R/Outpatie	IL 3 L DOA		Home 5□Res			
dlng I	After funer	tion:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investiga			28b. Time o Injury	Wo	ryat rk? Yes 2 ⊟ No	28d. Describe	how injury occur	rred	
To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		Certification:	3 Suicide 6 Could no 4 Homicide determin	ot be	ury - At hor c. <i>(Specify)</i>	me, farm, st	reet, factory, office		28f. Location City or To	(Street and Numi own, State)	ber or Rural Route Number,	
Hospital 24 hours a	To the Funeral Discompletely filled in	Medical Ce	29a. Certifier Check only one)	y Physician: To the best of Examiner: On the basis of and manner sta	f examinati	vledge, deat ion and/or ir	h occurred at the ti evestigation, in my	me, date and plac opinion, death occ	e, and due to the curred at the time	e cause(s) and m	anner as stated. and due to the cause(s)	3.
o the	omple	Mec	29b. Signature and title of certifier	and manner sta	atou.		29c. Licens	se number		29d. Date signe	ed (Month, Day, Year)	_
⊢ ≯	r ō			UN ZO			D	5170	5	8-15		
	10		30. Name and address of person v		eath (Item	23a) (Type)	Print) DR	. Hes	tminst	92, m	D 21157	

DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Johnson Sr. Bernard Harrison /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE GOOD SAMARITAN 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days **X**□ M 2 □ F Months Hours MD 217-50-4815 09 Director 11 59 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at 1X Yes 2 □ No items 23a or 28a-f shiner must be notified Baltimore Director NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 U.S.A. 21218 1654 Northwick Road Apt #1 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No "natural", or Baltimore, Maryland 21215-0036 Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Highways Laborer Department of Health and Mental Hygis Important: if Item 27 is marked other any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Viola Ringgold Charles Edward Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 of Health 1654 Northwick Road Apt#1, Baltimore, <u> Doris Johnson-Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Arbutus Memorial Park 8/21/07 Arbutus, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Ave, Baltimore, Md 21215 3a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho x, or heart failure. List only one cause on eacy ine. Approximate Interval Between Onset and Death Immedia e Cause (Final d seaso or condition resulting in death) Myocarchai 1 Hour **Physician** /Medical r as a consequence of): Due to (Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and s the burial-transit Exam Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2 No 2 1 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, P.O. Box 68760

the Hospital or Attending Physician; The law requires that the death certificate be executed Director:

within 24 hours a

To the Funeral C

State

6 ☐ Could not be

nd title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number August 16.2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Lock Raven Boulevard Bultimore 21239 ho completed cause of death (Item 23a) (Type, Print) 30. Nam MM) 5601

Registrar's Signature

and manner stated.

31. Date filed (Month, Day, AUG 2 Year) 1 2007

3 ☐ Suicide

29a. Certifier

29b. Signatury

Medical

4 ☐ Homicide

(Check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

t 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deat Physician /Medical Location of Death **Examiner** 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 M 2 □ F Director death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14 Bace spanic Origin? (Specify Yes or No n, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status Black, Whi 1 Never Married 2 Married 1 ☐ Yes 2 █ No Baltimore, Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working like. BO NQT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middl Be ဂ္ Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural R. ite Number, City or Town, State, Zip Code) ORAVIA 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) f Funeral Service Licensee 21. Signature 23a. Pert I. Enter tyle disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he be failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) meta stati eass **Physician** rostate Caricas /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to (or as a nunsequence of) Examiner Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by anemia 1 🗌 Yes 2 NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Souther (Specify) VISSICE 1 ☐ Yes 2 ☐ 10 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L Fig-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 D00514210 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - N. Charles & PPE 202 M Gordan Baltonono uno 2120 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1^{Day} 2007 6:25p Mildred August 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Days Hours Min 1 □ M 2 1 F 396-14-4627 Usual Residence of Decedent July 4, 1924 WISCONSIN 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 1 ☐ Yes 2 7 No 10WSON Baltimore MARYLAND 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21204 Leadburn 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) KESIDENCE HOMEMAKER 18. Mother's Name (First, Middle, Majglen Surname) 17 Father's Name (First, Middle, Last) KATHERINE orles HOPECKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) TOWSON Kichard Leadburn 20c. Location - City or Town, State KUPRO 20b. Place of Disposition (Name of cemetery, crematory or other place) Date August 25, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State IIMONIUM, MARYLAND 2007 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility ACEFUL PLTEINATIVES FUNERAL & CREMATION CTR. F.A. 21. Signature of Funeral Service Licens Timorium 21093 YORK Rd 2325 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause Unious Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Rheumatoid BUHNI M D 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an mellin DICHERS autonsy perform 2 **№** No 1 ☐ Yes 2 No VICENS Decibles 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Ex-miner must be notified at

be filed within 72 hours after untal Hygiene.

d other than "natural", or iter

if Health and Mental item 27 is marked o

and 2 should

Pages 1 ment of F Department of Important: If it any injury or conce.

Saltimore, Maryland 212

Completed by Funeral Director

Be

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/Medical

death certificate be executed burial-transi and physician a ass for signed by the a peen has e 2 page 2 this certificate or Attending Physician; director,

Records,

Division or Vital

Examiner Physician/Medical Completed by Be ٩ Certification: Virtual Director: Aff

To the Funeral Director: Aff

funeral

Medical

State Registrar

After

To the Hospital

IE EEMALE 23b. Was decedent pregnant

25. Was case referred to medical examiner?

4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

(Check only

29c. License number

Charles

STREET

29d. Date signed (Month, Day, Year) 812007

m.n 30. Name and aderess of person who completed cause of death (Item 23a) (Type, Print)

Scrye 20 31. Date filed (Month, Day, Year)

6701 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year AUGUST 8 14 AM 2007 4c. County of Death Facility Name (If not institution, 4b. City, Town, or Location of Death Baltimore TCU HVGB 8. Date of Birth (Month, Day, Year) May 13, 9 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 M 2 K Yrs. North Cerolena Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside Çity Limits 1 res 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 218 21 monti Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Donest Elementary/Secondary (0-12) College (1-4or 5+) maker 18. Mether's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) terstown Bacto, nd, 21215 Kd, 4500 Keis Kei 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State -24-07 4 ☐ Donation ⊅ ☐ Other (Specify) 22. Name and Address of Facility 270 Fred HIGTON Ma Funeral Home Balto, md, 21209 23a. Party Errer ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if he art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate car se (Final disease or condition resulting in death) MYOCARDIAL INFARCTION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STAGE RENAL DISEASE ON HEMUDIALYSIS 1 Yes 2 No 3 Probably 4 Whitenown ANEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed' 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 mpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident

Physician /Medical Examiner certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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items 23a

6

and Mental Hygiene.

Baltimore, Maryland 21215-0036

Box 68760,

o.

Records,

or Vital

Division or Attending

Hospital

Director

Completed by

other traumatic event, the Medical Examiner must be notified

physician and s the burial-transit as use been signed by the should be detached within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

attending

has

certificate

Examine Physician/Medical þ Completed Be P Certification:

Medical

5 Pending investigation

6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29c. License number

29a, Certifier

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

00061789

29d. Date signed (Month, Day, Year) AUGUST 19, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEUI LACH PAVEN BLUD, BALTINGRE, MD 21239 LORRAINE OFORI-AWUAHIND,

State Registrar 31. Date filed (Month, Day, Year) AUG 2 1



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** ROBERT LEE KIBLER 12:10 AM 8 16 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death **Examiner** OVERLEA NURSING AND REHABILITATION BALTIMORE BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1XXM 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Months 218-30-5495 2/27/2935 72 MARYLAND **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notifiled at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits BALTIMORE CITY 1 X Yes 2 No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6116 BELAIR ROAD 21206 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 100 lo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UNEMPLOYED UNEMPLOYED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM J. KIBLER, SR. LELIA M. WHITE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MR. GEORGE KIBLER - BROTHER 20625 KEENEY MILL RD., FREELAND MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of h Important: if ite any Injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State MEADOWRIDGE MEM. PK. 8/20/2007 4 Donation 5 Other (Specify) ELKRIDGE, MD 22. Name and Address of Facility SINGLETON FUNERAL HOME Service Licensee 21. Signal 1 2ND AVE. S.W., GLEN BURNIE, MD 21061 ma1120 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical Due to (or se a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an page 2 1□ Yes 2√No s after deau.. rai Director; After this cerum... Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manufer of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

N. Eutaw street, #308 Baltimore, MD 2/201

and manner stated.

821

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		rificate of L		Re	eg. No.	26789
E	Physicia		1. Decedent's Name (First, Middle, Las Margaret					2. Date of Death Month August	17 2007	3. Time of Death 5:50p M
Ã.	/Medic Examin	di.	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Death	-
	<u> </u>		2206 Riversid		and histogram	Essex	If Under 24 Hrs.	8. Date of Birth	Balti	nore place (State or Foreign
E	Funeral Director		219-42-9639	7. Age (In yrs. le		Months Days	Hours Min.	sept.	0,1943 MA	ryland
	land ow		Usual Residence of Decedent 10a. State 10b. County		, Town or Lo	cation				10d. Inside City Limits
	a-f sh	ctor	MD Baltin	iore	E	ssex				1 □Yes 2 X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	al Director	10e. Street and Number 2206 Riversio	le Drive		10f. Zip Code 2122	21	10	0g. Citizen of What Cou USA	ntry?
	tems ter mn	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	urs afte al", or i xamir	by	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2½ No If Yes, Give Year or Dates:		I□Yes 2∏xNo	Specify:		Specify: Wh	ite
21215-0036	72 hou 'natura dical E	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Deced	tent's Usual Occupa kind of work done of OO NOT use retired	ation during most of work	ing	16b. Kind of Business/In	dustry
121	within ene. than "	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		stom Ser			Federal	Government
d 2	illed Il Hygi other ent, tl	Se C	17. Father's Name (First, Middle, Last,)			18. Mother's Nam	e (First, Middle, N	Maiden Surname)	
ylar	ould be Menta arked aric ev	To Be	William Light	•			Doris			
Maryland	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (; City or Town, State, Zij ltimore Mi	
Б. _	tem 2		Robert Koch /h			sition (Name of matory or other plac Cremato		Date	20c. Location - City or T	own, State
altimore,	Pages nent or int: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State Bay	yview	Cremato	ory 8/2	21/07	Baltimro	e MD
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service Licer	see mull h		2. Name and Address Connelly	- 50		Ave Balto	
	蔥		23a. Part 1. Enter the disease, or conshock, or heart failure. List only						est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a METASTATI		INCREAT	1 CAM	cer		15 m 05
	Examiner			Due to (or as a consequ	uence of):					
	<u> </u>	iner	Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consecu	uence off:				7.8	
	xecute and Il-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):					
68760,	ficate be executed physician and is the burial-transit	edical E		⊸ d						
	ertificating phr		IF FEMALE:				-			
Box	that the death certifed by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 Live birth 2 Feta 4 Pregnant at time of decisions.	Ideath 3	Ectopic pregnancy Other (specify)	1		23d. Date of deliver Month	Pery Day Year
P.O.	that the ded by the detached	hysi	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	9☐Unknown						
	tw requires that s been signed t should be det	by	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did tol	bacco use contribute to es 2 No 3 Pro	the cause of death? bably 4 □Unknown
or Vital Records,	law req as beer 2 shou	Completed						24a. Was a		opsy findings available ompletion of cause of
Ä	The ate h page	Com						perform	med? death?	2 □ No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	ED/0 1	ot 3FT DOA Oth		th (Check only on		
	g Physer this eral dii	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	28b. Time o	11 3 DOX	4 Li Nursing Fi		ence 6 Other (Specow injury occurred	ify)
sion	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigatio		Injury	M 1 🗆	Yes 2 □ No			
Division	al or Atta after de Il Directa d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, st	reet, factory, office		28f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my kno miner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the tin	me, date and place opinion, death occu	, and due to the c rred at the time, c	ause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	/		29c. Licens	e number	2	29d. Date signed (Month	, Day, Year)
	<.		freshort for	ma fall		133	551	/	Hug 20, 2	1004
1	1		30. Name and address of person who	completed cause of death (Item 9/10 Philadol	23a) (Type,	Ro #3	14. BA	timore	2/23	7
İ	St Regist	ate rar	30. Name and address of person who Auer RBACH 31. Date filed (Month, Day, Year)	32 Registrar's Signal	ature	ale				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 14:39PM Robert Edward Long, Sr. Aug 14 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St Agnes Battimore health care If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2□F Yrs. 220-36-1647 Director 66 Sept 28. 1940 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD n/a Baltimore 1 X Yes 2 □ No Director 10e, Street and Number 10f Zin Code 10g Citizen of What Country? 1633 Parkman Avenue U.S.A. 21230 Funeral 2 should be filed within 72 hours after death v n and Mental Hygiene. 'Is marked other than "natural", or items 23s 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No ş Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Industrial Cleaning 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Robert Long Margaret Evelyn Gray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra Nellie Long/Wife 1633 Parkman Avenue Baltimore MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Arundel Crematory 8-20-2007 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal-from State Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licert ee Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, Md 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia Acinetobacter 2 months /Medical Due to (or as a consequence of) Examiner Emphysema 5 years Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or all a consequence of) be executed burial-trar Due to (or as a consequence of) attending physician for use as the buria Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) is certificate has been signed by the director, page 2 should be detached 9 I Inknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4 X Unknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. after death filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours a Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 24

State Registrar 29b. Signature and title of certifier

Jyothi Punnam

31. Date filed (Month, Day, Year)

> Typthi Puman

the within 2

900 S. aton avenue, Baltimore

29c. License number

P19925

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

The care

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H			iene	a region	26791
	Physici	2 P	1. Decedent's Name (First, Middle, Last)	T h A h	aham I and			2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic	al		Joseph Abr	anam Lord	4b. City, Town, or	Leasting of Do	August	4c. County of	.007	3:30 A. M
	Examin	er	4a. Facility Name (If not institution, give s 320 Seward A				timore		A		undel
- 4	Funeral Director		5. Social Security Number 6. Sex		(In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		1,1929	Count	lace (State or Foreign try) y Land
			Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	reation				10	0d. Inside City Limits
	ith the Marylar or 28e-f show e notified at	ō	,	rundel	Baltimo						1 ☐ Yes 2 🛣 No
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	th with	al D	320 Seward Avenu	ue		1	225		U.S.		
336	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other traumatic event, I'm Medical Evantinet must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E- Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		White, e	
5-0	72 hor	eted	15. Decedent's Edu	cation completed)	16a. Dece (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of v	vorking	16b. Kind of Bus	siness/Ind	lustry
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/an	Jid be Jental rked c	To Be	Soloma Soloma	an Abrahan				y Pinder			
Maryland	2 shot and h Is ma		19a. Informant's Name/Relationship (Ty					Rural Route Number Baltimore			
	1 and Health em 27 Iher tr	1 8	Margaret Lord /	wife	32U 20b. Place of Dispo cemetery, crei	Seward Av			20c. Location - (
nor	ages ent of h it: If ite y or o		1 ☑ Surial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Cedar Hi	natory or other place 11 Cemete	ery 8/	20/2007	Baltimor	e, M	lary1and
Baltimore,	perniit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, Item Manginge.		21. Signature of Funeral Service License	99	A 2 4	2. Name and Addre	ss of Facility	Gonce Funday Balt	eral Ser imore, N	rvice laryl	P.A. and 21225
54.	DX. 10. 3		23a. Part1. Enter the disease ir complishock, or heart fallure. I st only or	ications that caused to	the death. Do not ent					Ť.	Approximate Interval Between
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68	certificate be nding physicia use as the bur	edic		j							
P.O. Box	requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	4		23d. Date Mon		ery Day Year
	law requires that the death as been signed by the atter 2 should be detached for u	by	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the u	inderlying cause av	on in Part P	23e. Did to			ne cause of death?
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/ita	cian: entifica ector.	Be	25. Was case referred to medical examiner?	lospital: ,		ac pos oth	200	Death (Check only or			
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ion	nding tth. :: After e fune	atlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) Injury	Wor	rk? ∣Yes 2 □ No				
Divis	of or Atternation after description of the descript	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Tow		or or Rura	l Route Number,
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Physical (Check only 2 Medical Exeminate)	sicien: To the best o ner: On the basis of and manner stat	examination and/or in	h occurred at the tire	me, date and pla opinion, death o	ace, and due to the occurred at the time, o	ause(s) and mai late and place, a	nner as st and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	lingh	- M.D	29c. Licens	(416	OA	29d. Date signed	(Month,	7, 2007
	1401		30 Name and address of person who	implying cluse of de	ath (Item 23a) Type,	Print 40	-AR	IT CHIL	= HG	HV	TAY
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 1 200	2. Registra	's Signature	de la	MA	KYCA	MD ?	2-(113

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	8	1. Decedent's Name (First, N	fiddle, 'Last)						2	2. Date of De	eath		- I	3. Time of Deat
Physici /Medi		LARRY ST	EVEN N	MOSS						Month	TIG	, 20	Year 7	0408
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		5. Social Security Number	6. Sex	grone 7. Add	- (In vrs.	last birthday)	If Under 1 Ye	ar If Under 2	24 Hrs. 8	B. Date of Bi		rince		place (State or Fore
uneral irector		379-56-2333		1 2□F	56	Yrs.	Months Day		Min.	(Month, Da	av. Year	950 1	Cour	ntrv)
_		Usual Residence of Deceden			40- 00	Ť	-11							
show ed at	2	10a. State 10b. Co	1			y, Town or Loc	ation						1	1 □Yes 2 □
a or 28a-f sh be notified	Director	MARYLAND ANN 10e. Street and Number	E ARUNI)EL	L.	AUREL	10f. Zip Cod	9			10a Ci	tizen of W	hat Cour	1 ☐ Yes 2 ☐
3a or		246 SYCAMORE	RIDGE F	ROAD			207					S.A.	nat Ooui	16 y .
r mus	Funeral	11. Marital Status	12.	Was Decedent 8 Armed Forces?	er in U	S. 13. V		of Hisp <i>a</i> nic Original	gin? (Speci	fy Yes or No		14. Race		an Indian,
natural", or items 23a dical Examiner must t	þ	3 Widowed 4 Divo		1 ☐ Yes 2000 If Yes, Give Year or Dates:	No		Yes XX		i, rueito Ai	can, etc.)		Specify:	white,	etc. ITE
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day 30 PM ARI KIUST 04 20007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE BAYVIEWMEDICALCENTE HORKINS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**28**44 2□ F Months Days Min. Hours Director May 20 Maryland Usual Reside nce of Decedent 10a. State 10c. City, Town or Location show. 10d. Inside City Limits be notified at 1 es 2 No Director more 28a-f 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a or USA 14. Race - American Indian, Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 'natural", or 1 ☐ Yes 2 X No Specify. \$ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business/Industry important: If item 27 Is marked other than any Injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Pages 1 and 2 should be Department of Health and Mental 19a. Informant's Name/Relationship (Type. Print) (MOTHER) 19b. Mailing Address (\$treet_and Number or Rufal Route Number City or Town, State, Zip Code) Janice Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Sig ature of Funeral Service Licensee 22. Name av Address of F JOSEP L. R 2222 W. NOR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY FAILURE LHOUR /Medical Due to (or as a consequence of): Examiner RENAL FAILURE 2 WEEKS Sequentially list conditions, if any, leading to in a relative cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dure to for as a registrous record requires that the death certificate be executed HEPATIC FAILURE burial-tra Due to (or as a consequence of): Box 68760 Physician/Medical HEPATITIS the as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) Vital Records, P.O. 9 Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HEPATITIS page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe rmed? 2 No 1 director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1∕ Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 0 this 24 hours after death.

Funeral Director: After thi etely filled in by the funeral or Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) sompletely

DHMH 17 Rev 1/2001

State Registrar

within 2 To the

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Cartos Weiss, MD

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(a Hos Weiss; MD 5200 Eastern Ave.

32. Reatrar's Signature

29c. License number

D60052

Bullimore

MD

29d. Date signed (Month, Day, Year)

08/17/2007

21224-2734

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Miller 1600 Maureen August 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Hospital Johns Hopkins Bayview Bultimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan 6,1949 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Months 1 M 2 XF Pennsylvania Jan. 174-40-7714 58 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 🙀 No Director PA York Manchester 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? d 2 should be filed within 72 hours after death with th and Mental Hygiene. 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 105 Rosedale Drive 17345 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Francis McAllister Margaret Milbrand 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 i Emory Miller-Husband 105 Rosedale Drive Manchester, PA 17345 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Saint Edward Cemetery 8/22/07 Coal Township, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Charles S. Zeiler & Son Inc. 21. Signature of Funeral Service Licensee 6224 Eastern Avenue Baltimore, Maryland 21224 23a. Fart1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Gram negative Scotteemier 1 doug disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** bucteremen Multi-organism v 3 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and alceration V6 months requires that the death certificate be executed as the burial-transi Desquanination and Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria ~5 years Syndrome Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? res 2**X**I No certificate 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 215No 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ After this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 Accident To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A' completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier াৰ্দ্ৰ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Eastern Avenue 4940 Town ner 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



DHMH 17 Rev 1/2001

Registrar

MD

29c. License number

10-0058893

Bail timore

29d. Date signed (Month, Day, Year)

August

MD

2007

21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 19:43 P M James L. Mills AUGUST 2007 13 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SAINT BALTIMORE AGNES MOSPITAZ If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 X M 2 □ F Hours Yrs 218**-**62**-**1816 46 Mar. 9. 1961 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1236 Leeds Terrace 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Rebb's Chocolate Candy Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank R. Mills, Jr. Dorothy Tobin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve Mills - Brother 5 Albright Court, New Freedom, PA 17349 20b. Place of Disposition (Name of cemetery, crematory, or other place) West Arundel 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 8-18-2007 Odenton, MD Crematery 22. Name an Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Juneral Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTISYSTEM ONE DAY ORGAN FAILURE Due to (or as a consequence of): SEPSIS ONE DAY Due to for as a consequence off CONGESTIVE HEART FAILUKE 4 YEARS Due to (or as a consequence of): ATRIAL FIBRILLATION, 4 EARY If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

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Division or Vital Records, P.O. Box 68760,

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M

Baltimore, Maryland 21215-0036

Sequentially list conditions, leave Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an performed? Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

			18 18 28 18 18 18 18 18									
25	. Was case referred to medical examiner?	26. Plac	26. Place of Death (Check only one)									
	1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ N	lursing Home 5 ☐ Residence 6 ☐ Other (Specify)									
27	Manner of Death 1 Natural 5 Pending 2 Accident investigatio		28d. Describe how injury occurred									
	3 Suicide 6 Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)									

29a. Certifier (Check only one)

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

BALTIMOKE

M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month. Dav. Year) 1 20347 AUGUST 13,2007

State Registrar

JAIN 900 AVENUE CATON 32. Registrar's Signature Year) 31. Date filed (Month, Day, AUG 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🥍 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 0 **Physician** 18:10 PM 2007 Goldie May McNamara /Medical 4a. Facility Name (If not institution, give street and number)

ST ACTNES HOSPIT 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 212-34-4368 1 ☐ M 2 🂢 F 71 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f ehow The Medical Examiner must be notified at MDn/a Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 820 S. Caton Avenue Apt 9K 21229 filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2X No Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiens Important: If item 27 is marked other that any injury or other traumatic event, ITE. 8 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Ash, Sr. Ethel May Heinlein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. McNamara, Jr./Husband 2684 Dulany Street Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place Crestlawn Memorial 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐Donation 5 ☐ Other (Specify) 8-17-2007 Sykesville, Maryland Gardens Ambrose Funeral Home, Inc. 1328 Sul hur Sprin Rd.Arbutus MD 21227 21. Signature of Euneral Service Licensee 1400235 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) temorrhagic Snock Physician hours /Medical Examiner Hortic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Division of Vital Records, P.O. Box 68760, Blood Physician/Medical attending for use as IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Probably 4 Unknown 1 TYes 2 No. certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tes ဥ 2000 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No М investigation 2 Accident I hours after death uneral Director; 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the within 24 hours a...
To the Funeral Dir Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check unity one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 13, 2007

DHMH 17 Rev 1/2001

State

Registrar

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32. Registrar's Signature

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Caton

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

AUG 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 9005 /Medical 18 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital ALTIMORE 7. Age (In yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) ocial Security Number 6. Sex (last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 💢 F Director Carole Narth Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1. Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 6 Funeral 12. Was Deceden Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Neyer Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 2 Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DQ NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Howard = 12 should be filed w h and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bettie Smit Pages 1 and 2 should ပ un Ki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any Injury or other trau Son Windson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1⊠Burial 2 □Cremation 3 □Removal from State men 18 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service License and Address of Facility m. wa 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaf failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed and Due to (or as a consequence of): burial-Records, P.O. Box 68760 attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Ş s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by -a. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an After this certificate has funeral director, page 2 s autopsy perform 2 No Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 | Inpatient 2 ER/Outpatient 3 DOA Division or 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours at 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) D 47353 August 18, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bathonore, Maryland 21229 Jon Falck, Mi) 900 Caton Avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AUGUST Year Physician 2:20PM May Morton 2007 14 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL BAUTIMORE SIMAI Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 □ F Yrs. Director 90 26 WV 219-18-4890 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County or items 23a or 28a-f show miner must be notified at 1X Yes 2 ☐ No Directo Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 U.S.A. 14. Race - American Indian. Funeral 4001 Clarks Lane #505 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. other traumatic event, the Medical Examiner 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify. Black Completed by 3 Widowed 4 □ Divorced "natural" 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore City d 2 should be filed within 72 th and Mental Hygiene.
7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Substitute_ Teacher Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mattie White Charles Edmonds 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5400 Wabash Ave, Baltimore, Md 21215 Frances Gaines-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o
once. Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 8/21/07 Owings Mills, Md
22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Obstructi **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the hurial Physician/Medical IE EEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregrant 3 ☐ Ectopic pregnancy Month in the past 12 mor 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 Tes page 2 should 24a. Was an 246. Were autopsy findings available prior to completion of cause of nerformed death? 1 ∐ Yes 2 No 2 certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Medical Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DØØ63430 AUGUST 14 2007

Registrar

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31. Date filed (Month, Day, Year)

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32 Registrar's Signature

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BALTIMORE MD 21215.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Norma M. Meise 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Woods Nursing Center Rosedale Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Aug. 11, Year) 924 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 1 F 218-14-1169 Maryland 83 Director Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show any injury or other traumatic event, it a Modical Exertiner must be notified at Baltimore MD Middle River 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 10312 Bird River Road USA "natural", or Itams 23a death 1 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White à 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If itam 27 Is markad othar than * Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Laubach MArgaret Fitch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 64 A Get Around Drive Colora MD 21917 Rosalie Sniadach /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If Holly Hill Cemetery 8/22/07 Baltimore MD 4 □ Donation 5 □ Other (Specify) 21. Signature A Funeral S. 22. Name and Address of Facility once. 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Jostridium disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician P.O. Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 ☐ Ectopic pregnancy ō Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 1 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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07-06378

James Arthur Miller

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Division of Vital Records, P.O. Box 68 tal or attending Physician: The law requires that the death certif its after death. al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as ertification: To Be Completed by Physician		ther significa	nt conditio	ons contribu	ting to death	but not re	sulting in t	ne un	gerlying cause	given in	Part I.		portaling	portaling	bably 4 VI Unknown
Records, The law requires frate has been signage 2 should be Completed	-											24a. Was	an 24		utopsy findings available
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Division ospital or Attending hours after death. neral Director: Aft. filled in by the func. Certification:	3 _ s	uicide 6	Could	not be 28e	. Place of Inj	ury - At ho	me, farm,	street	, factory, office	building		or Town, S	State)		ural Route Number, City
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Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician	(Check only one)	y I L Cer		iner:On the b								due to the caus t the time, date			
A S T S T S	29b. Sign	ature and title	of certifier	and mai	iller stateu.				29c. Licer	nse numb	oer OCMI		29d. Date s	igned (Mo	onth, Day, Year)
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2		and address			-				144 D- 0	tre-t	Daltim -	MD 2400	1		
		odore M. K			sistant M 32. S gistrar			1	PennS	ureet, l	oaiumore	e, MD 2120	1		
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DHMH 17 Rev 1/2001							ORIGI	NAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** NUNLEY 8:06 pM DOROTHY W. 08 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9260 Cherry Lane, Unit 33 Prince George's Laurel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 17, 9. Birthplace (State or Foreign **Funeral** 1□ M 2□ F Months Days Hours Min 1931 Maryland 76 Director 218-24-3064 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Michael Examinar and injury or other traumatic event, the Michael Examinar and injury or other traumatic event, the Michael Examinar and injury or other traumatic event, the Michael Examinar and injury or other traumatic event, the Michael Examinar and injury or other traumatic event, the Michael Examinar and injury or other traumatic event, the Michael Examinar and injury or other traumatic event, the Michael Examinar and injury or other traumatic event, the Michael Examinar and injury or other traumatic event, the Michael Examinar and injury or other traumatic event, the Michael Examinar and injury or other traumatic event, the Michael Examinar and injury or other traumatic event, the Michael Examinar and injury or other traumatic event, the Michael Examinar and Injury or other traumatic event, the Michael Examinar and Injury or other traumatic event, the Michael Examinar and Injury or other traumatic event, the Michael Examinar and Injury or other traumatic events and Injury or other traumatic events and Injury or other traumatic events and Injury or other traumatic events and Injury or other traumatic events and Injury or other traumatic events and Injury or other traumatic events and Injury or other traumatic events and Injury or other traumatic events and Injury or other traumatic events and Injury or other traumatic events and Injury or other traumatic events and Injury or other traumatic events and Injury or other traumatic events and Injury or other events and Injury or other events and Injury or other events and Injury or other events and Injury or other events and Injury or other events and Injury or other events and Injury or other events and Injury or other events and Injury or other events and Injury or other events and Injury or other events and Injury o 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits 1 ☐ Yes 2☐ No Director MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9260 Cherry Lane, Unit 33 20708 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 🗓 o Specify. Specify: δ White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
Grade 11 College (1-4or 5+) Electronic Firm Purchasing Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Doc Riley Katie Jordan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Collins daughter 318 Hudson Road Corinth, Maine 04427 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Veterans Cemetery 8/20/2007 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility al Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or shock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner The law requires that the death certificate be executed physician and the burial-transit to (or as a consequence of) Physician/Medical as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 2 10 1 Yes the 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy perform 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA P 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day,

Division or Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year AN -IVER 6:60AM 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, NURSING HOME 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 86-1**⊠**M 2□ F Months Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MARVLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced To Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) THGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NNET 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 75B. ULTON AVE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Malignant disease or condition resulting in death) Due to (or as consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 □Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ⅳ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 1 Yes **2**☑ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of Injury 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred 1 Natural (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

The law requires that the death certificate be executed burial-tran attending physician ed by page 2 this certificate Vital Attending Physician: Division or funeral After death. within 24 hours after deatl To the Funeral Director: filled in by ö

Funeral

Director

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Pages 1 and 2

permit. Pages 'Department of Important: If ite any injury or of

Physician

/Medical

Examiner

Maryland

event, the Medical

other traumatic

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DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 2 1 2007

Registrar's Signature

1600

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

W. MOUNT

75

3

29d. Date signed (Month, Day, Year)

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07-06440								
Beulah Prioleau								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Segian Photeau	1- For State	Certific	ent of Health an cate of Death	u Meritai Hygi	Reg. No.	2007	
Physician/		t)			Pate of Death	Year 0440	
Medical Examine	Beulan Pilo	leau		A	ugust 20, 2007	0140	hrs
K. AP	4a. Facility Name (if not institution, given Sinai Hospital	e street and number)	4b. City, Town, or Baltimore	Location of Death	4c. C	ounty of Death	
Funeral	Social Security Number 6. S	ex 7. Age (In yrs. last bit		ar If Under 24Hrs. 8.	Date of Birth (MM/DD	/YYYY) 9. Birthplace (S	tate or
Director	217-80-3870 1 Usual Residence of Decedent	M 2 XF 48	Yrs. Months Day	rs Hours Min.	6/06/195	ForeignMary	land
any	10a. State 10b. County	10c. City, Town	n or Location		·	10d. Insid	de City Limits
and show	Maryland		Baltim	ore		1 XY	es 2 No
the Maryland as 28a-f show tiffed at once.	10e. Street and Number		10f. Zip Code		.,	of What Country?	
ith the Maryland 23a or 28a-f sho notified at once.				1213	U.S.		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. To the Conferent of the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Mantal Status 1 X Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? ('Specify n, Mexican, Puerto Rica		. Race - American Indian White, etc.	, Black,
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omp	11 17. Father's Name (First, Middle, Last		Laundry Wo	rker 18.Mother's Name (Fin	st Middle Maiden Su	Laundry	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examing To Be Completed by		ype, Print)	9b. Mailing Address (Stree				;) .
MD d 2 sh lith an n 27 i	Romona Prioleau 1	ogan/Sister 3	907 Kenyon A	ve., Baltii	more, Mary	land 21213	
ore, of Hea If ite	20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State crema	of Disposition (Name of ce atory or other place)	08/25	/2007	cation - City or Town, Sta	
Page ment tant:	4 Donation 5 Other Specify	King	Memorial Pk.			imore, Mary	
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If iten 27 is marked other tt injury or other traumatic event, the Med	21. Signature of Funeral Service Licer	see	22. Name and Address	s of Facility The D	errick C.	Jones F/H,	P.A.
Physician	23a. Part I. Enter the disease, or comp		14611 Park	Hats. Ave.	, Baltimor	or heart Approx	imate Interval
/Medical	failure. List only one cause on e- Immediate Cause (Final disease a	schline. Seizure disorder		1.7		Betwee	en Onset and Death
Examiner	or condition resulting in death)	Due to (or as a consequence of):					
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i i i i i i i i i i i i i i i i i i i	cause. Enter Underlying Cause (Disease or injury that mithated	- 113-4					
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b. Box 687 the death certific the death certific by the attending ched for use as t Physician/	1 Yes 2 No 9 V Unknow	Pregnant at time of death 9 Unknown	5 Other (Specify)				
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans Medical Certification: To Be Completed by Physician/Medical E.	one) 2 Medical Examine	On the basis of examination and/or and manner stated.					
	29b. Signature and title of certifier	(1)	29c. Licens			te signed (Month, Day, Y	'ear)
, 1	Mhna Blasse	V, MIG		M.E.	Augus	st 20, 2007	
Organ	30. Nalle and address of person who Melissa Brassell, MD A	completed cause of death (Item 23a) ssistant Medical Examiner	111 Penn Street, E	Baltimore, MD 212	201		
State		32. Registrar's Signature	1 4				
Registra		107 Keen St	pour				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** ARK AUGUS 16 200 HVUN JOONG /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner BALTIMORE UNIVERSITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 12/19/196 9. Birthplace (State or Foreign (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1. M 2□ F SOUTH KUREA 214-13-3772 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location should be filed within 72 hours after death with the Maryland not Mental Hygiene. 10a. State 10b. County 1 ☐ Yes 2 No Baltmore Directo MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 Completed by GREAN 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation item 27 Is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EMPLOYED -19wr STURE OWNER 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210.93 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an Way ApT. Nightingale Lutherville mo ARK - BROTHER Health tem 27 I Department of Heall Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🕍 Cremation 3 ☐Removal from State FOREST HILL MARYLAND 18,2007 FUNERAL CHAPEL 4 □ Donation 5 □ Other (Specify) Name and Address of Facility NES FINERAL & CREMATION CTR., P.A. 21. Signatul Funeral Service Licens 21093 TIMONIUM, MD YORK ROAD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 6 months **Physician** /Medical e to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hyperlen

Due to (or as a consequence of): The law requires that the death certificate be executed IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. Be Completed by 1 Yes 2 No 3 Frobably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Impatient Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٥ August, 17th 2007 D34974 Mohta MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARUMEHTA, MD, 601, South charles street, Baltimore, MD21230

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 10:55 a Perry 2007 Clifton August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Months Days **X**□ M 2□ F 79 09 MD Director 216-20-3697 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygene. Important: If term 27 is amarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at ty⊡Yes 2 □ No Baltimore Directo NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 U.S.A. 3110 Leighton Ave Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married X ☐ Married 1 ☐ Yes X☐ No Specify: Black ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Post Office <u>12th grade</u> Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill f Health and Mental H tem 27 Is marked oth Be Bectrice Nugent ပ Edward Perry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3110 Leighton Ave, Baltimore, Md Catherine Perry-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 □ Cremation 3 □ Removal from State Garrison Forest Vet. 8/24/07 Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) Sanatura of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. P.rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imprediate Cause (Final disease or condition LUNG Physician sulting in death) /Medical Due to (or as a consequence of) Examiner 0 Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): iner Exami ng physician and as the burial-tran Due to (or as a consequence of): Physician/Medical attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy 5 □ Other (specify) ___ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 10 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes 2 this Director: After that in by the funeral 27. Manner of Death Natural 28a. Date of injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

death certificate be executed Records, P.O. Box 68760,∜ or Vital To the Hospital or Attending Physician: Division death. within 24 hours aft

To the Funeral Di

completely filled in

filed within 72 hours after death with the Maryland

altimore.

4+1

DHMH 17 Rev 1/2001

State Registrar

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAYMOND A. NZEMD, 780/
RAYMOND A. NZEMD, 780/
Replaced (Month, Day, Year)
Replaced (Month, Day, Year) 780/ YORK RD#100, TOWSON, MO 21204

29a. Certifier

(Check only one)

29b. Signature and title of certifier

1

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

IdmAN

Aegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARUIN

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

007930

2401 W Belvorlere Ave, Balto Md 2/2/5

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

MARYLAND ROEPKE

Fu Dir

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Phys /Me Exa

Baltimore, Maryland 21215-0036 AUGUST 18, 2007 9:15 a.m.

State Registrar

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

TIMONIUM, MD 21093

120/07

RICKTOR $^{\circ}$ HELEN altimore, Maryland 21215-0036

		•	For State Registrar	State of Mi	arylaric		rtificate of l				eg. No.	107	26800
ď	Discription in the		1. Decedent's Name (First, Middle, L	ast)						Date of Dear	Day	Year	3. Time of Death
	Physicia /Medic		Helen Clare Ric	ktor			r			061057	12	2007	415 PM
	Examin		4a. Facility Name (If not institution, gi	^	2		4b. City, Town, or		of Death		4c. Cour	nty of Death	
7			SINAI HOSPITIO			ist birthday)	BALTIM If Under 1 Year		r 24 Hrs. 8	Date of Birth		N/A	place (State or Foreign
и	Funeral	1	,	1 M 2 XF 7. A9	je (ili yrs. ia	Yrs.	Months Days	Hours	Min.	(Month, Day	, Year)	Cou	ntry)
~	Director		218-09-0864 Usual Residence of Decedent		8/			l	<u> </u>	Jul. 19	9, 192	U	aryland
	yland now at		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	e Mar a-fsl	cto	MD N/A				Baltimore						¹₹ Yes 2□No
	or 28	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen o	of What Cou	ntry?
	ath w	ral	1707 Cole Stree		Surviva II G	140		1223	wining (Cannife	. Voc. or No.		ted Stace - Ameri	
	item:	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces?		i. 13.	Was Decedent of H If Yes, specify Cuba	an, Mexica	an, Puerto Ric	an, etc.)		lack, White,	
36	ırs afi li", or xami	by F	3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 🛣 If Yes, Give X Year or Dates:			1 □.Yes 2 No	Specify	<i>/</i> :		Spec	cify: Wh:	ite
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medral Examiner must be notified at ance.	te g	15. Decedent's (Specify only highest g	Education		16a. Dece	dent's Usual Occup	ation	st of working		16b. Kind of	Business/Ir	ndustry
215	thin 7 le. lan "r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired	d)	or or morning				
	ed wi ygien ver th rt, th	ပ်	12				Clerk	19 Moth	ner's Name (F	iret Middle	Stat	e of l	Maryland —
gu	be fill ad oth even	æ	17. Father's Name (First, Middle, Las	St)					·		Maideri Surri	aniej	
Maryland	should Ind Men marke	우	John Leap 19a, Informant's Name/Relationship	(Type Print)		19b. Maili	ng Address (Street		Lare_Ur ber or Rural F		r. City or Tow	vn. State. Zi	p Code)
Ma	d 2 sho th and 27 is ma trauma		Mary Clair Nels		ter		Leisure						,
	thealth tem 27 other tra		20a. Method of Disposition		20b. Pl	ace of Dispo	osition (Name of matory or other place	- 1	Date		20c. Locatio		own, State
m 0	Pages nent of I int; If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Donation 5 ☐ Other (Spec	☐Removal from State cify)	Wes	t Arui	ndel		8-14-2	2007	Odent	on, M	D
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Fig.	ensee	H		LOTY 2. Name and Addre			prose 1	Funera	1 Home	e, Inc.
Δ_	o a E e		Callener	WAX	4		1328 Sulp					s, MD	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause ly one cause on each I	d the death ine.	. Do not en	ter the mode of dyir	ng, such a	s cardiac or re	espiratory arı	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. SEPS	15								
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):							
		ia l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as	a consequ	ence of):						- 14	
V	uted J ansit	Ë	cause. Enter Underlying Cause (Disease of Injury that initiated events	A Lambara									
oʻ.	tificate be executed ig physician and as the burial-transit	Examiner	resulting in death) Last	Due to (or as	a consequ	ence of):					_		
68760,	ite be iysicia ne bui	edical	•	d									
_			IF FEMALE:			-					1	100	
Вох	ath ce ttendi or use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐Live birth	2 Fetal	death 3	Ectopic pregnanc	у				Date of delive of Month	very Day Year
0	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant a 9⊡Unknown	at time of de	eath 5	Other (specify) _						
P.O.	The law requires that the death cer tte has been signed by the attendin tage 2 should be detached for use	P	Part II. Other significant conditions	contributing to death I	out not resu	Iting in the u	inderlying cause giv	en in Par	t 1.	23e. Did to	bacco use c	ontribute to	the cause of death?
ds,	uires sign Id be	Completed by	HTN							1 □ Y	′es 2 □ No	3 🗆 Pro	obably 4 Unknown
00		lete	ANEMIA							24a. Was a		b. Were aut	topsy findings available
Re	Physician: The lav r this certificate has ral director, page 2	mo	-		_						rmed?	pnor to c death? 1 □ Yes	ompletion of cause of 2☑ No
ţa	an: rtifica tor, p	Be C	25. Was case referred to medical					26. Pla	ce of Death				
r <	dii ys	To B	examiner? 1 ☐ Yes 2X No	Hospital: 1 Inpat	ient 2 🗌	ER/Outpatie	nt 3□ DOA Oth	ner: 4□I	Nursing Home	5 🗆 Resid	dence 6 🗆	Other (Spec	sity)
n 0	ng Pl (fter th		27. Manner of Death 1 ★ Natural 5 □ Pending	28a. Date of Inj (Month, D		28b. Time of Injury	Wo			d. Describe h	now injury occ	curred	
sio	Attending I or death. ector; After by the funer	catio	2 Accident investigat 3 Suicide 6 Could not		ive. At he]Yes 2[Looption (6	Stmot and No	mhor or Pu	ral Route Number,
Division or Vital Records,	or At ifter d Direct in by	Certification:	4 Homicide determine	Zoe. Place Ul II	itc. (Specify	me, iarm, si	reet, factory, office		201	City or Tow		iniber or nu	rai nodie Namber,
ш	spital ours a leral filled		29a. Certifier VX Certifying	Physician: To the bes	t of my know	wledge, dea	th occurred at the ti	ime, date	and place, an	d due to the	cause(s) and	manner as	stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medicel Ex	aminer: On the basis and manner s	of examinat	tion and/or i	nvestigation, in my	opinion, d	eath occurred	at the time,	date and pla	ce, and due	to the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier	0			29c. Licens				29d. Date sig		
			1 Hu	mp			De	63 17	70		Hoy	12	2007
	2		30. Name and address of person w	completed cause of home and home are seen as the seen	death (Item	23a) (Type	Print)				U		
	9		31. Date filed (Month, Day, Year)	1000 Hon	D) W	ture	BOHN	rove					
	Sta Regist	ate rar	ALIG 2.	2007	Maria .	13 A	porte						
			FIGURE .	- D									

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State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 04:30 A M RAGISDALE AUGUST KELLY 13 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HARBOR N/A HOSPITAL If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6 Sex **Funeral** Months 1 □ M 2 😿 F 540 88 4001 42 May 13, 1965 Director <u>Oregon</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Maryland N/A 1X Yes 2 No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4704 Charleston Street 21225 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 2 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) 10th College (1-4or 5+) Sales Clerk permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen. Important; If Item 27 is marked other tha any Injury or other traumatic event; the kone. Retail Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Holbrook Loretta Green 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 98604 19a. Informant's Name/Relationship (Type. Print) Raymond Holbrook / Father 21907 N.E. Rock Creek Canyon Rd. Battle Ground, WA. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Bayview Crematory 8/16/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Fune al Service 4001 Ritchie Highway Baltimore, Maryland 21225 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Inter the disease, or complications that caused in shock, or heart failure. List only one cause on each lin Immediate Cause (Final Wee **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner oholic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine supraventrice Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4□Pregnant at time of death ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performe 1☑ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2<mark>⊠</mark> No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA ျ 1 🗌 Yes completely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore,

sician and burial-trans 24 hours after death. e Funeral Director; After

29a. Certifier

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

RES 000

29d. Date signed (Month, Day, Year) August 13 2007

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr Mamatha Phabhakan, 3001, S. Hanover Street, Baltimore, MD 21225

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 2 1 2007



within 2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate			g. No. 007	25310
	Physic	ian	Decedent's Name (First, Middle, Last)		2. Dete of Death	-	3. Time of Death
	/Medi		SHIRLEY LEEJE	T	Ø -	10 - 0) lothin
4	Examir	ner	4a Fecility Neme (If not institution, give street end number)	4b. City, Town, or Lo	ocation of Deeth	4c. County of De	eth .
	Funeral		Milester V		8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Di Usuel Residence of Decedent	ays Hours Min.	7-27-1		Md.
	how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	the Maryler 28e-f ehow	cto	Md. NA Baltimore				Y⊟ Yes 2□ No
	ith with the 23 a or 23 and 23 and 24 and 25	ai Dire	10e. Street end Number 1300 E. Lanvale Street Apt. 816	21202	10	g. Citizen of What USA	Country?
Maryland 21215-0036	filed within 72 hours effer death with the Marylend hygiene. ther than "natural", or Itema 23a or 28e-f ehow ont, the Medical Examiner must be notified at	by Fur	11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? 1	of Hispanic Origin? (Speculon, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify:	merican Indian, hite, etc. Black
5-0	72 ho	e e	15. Decedent's Education (Specify only highest grade completed) (Give kind of work de life. DO NOT use re	cupation	ina 10	6b. Kind of Busines	ss/Industry
121	Althin hen.	Be Completed	Elementery/Secondary (0-12) College (1-4or 5+)	tired)	,,,,		
d 2	Hygle ther ther ther	ပ္	10th grade NA Unemploye	18. Mother's Name		NA aiden Sumame)	
jan	Mentel Mentel arked o	To Be	Soloman Reese	Shirle	. , ,	Parke	er
ary	2 shou end N le mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (St.				
	end 2		Joyce Parham Cousin 11 W. 20th				, Md. 21218
nore	Pages 1 ent of H it: If Ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Denation 5 □ Other (Specify) 20b. Place of Disposition (Neme of cemetery, cremetory or other Mt. Carmel Cem.	plece)		oc. Location - City of Dundalk,	
Baltimore,	Demit. Pages 1 end 2 should be filed within Depertment of Heelih end Mentel Hyglene. Important: If Item 27 le marked other than any Injury or other treumatic event, the Mones.		21. Signature of Funeral Service Licensee 22. Name and Ad	Idress of Fecility	larch F.H	I. East	no.
_	00 E 0 0			North Ave.			21202
2			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock or heart failure. List only one cause on each line.	dying, such es cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
4	Physician /Medical		Immediate Cause (Final	7	0'	C. 1	
	Examiner		Immediate Cause (Final disease or condition resulting in death) a. End Stage Acquired Due to (or as a consequence of):	2mmela000	ficiency	syna	1
/	pe als	iner	B HIV				
∜ oʻ	The law requires that the death certificate be axecuted ate has been signed by the attending physicien and page 2 should be detached for use as the burial-trensit	edicai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause, (Disease or injury c.				
68760,	icate ba physicia s the bu	dicai	Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of):				
Box 6	aath certific attanding p for usa as	400	d				<u> </u>
	daath ne atta ed for	sicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23b. Did tob	acco use contribu	ite to the cause of death?
P.0	that the day ned by the a detached f	Physician/N	FAILURE TO THRIVE			2 □ No 3 □	. /
ds,	signe d be c	d by			24a. Was an	autoney 24h	b. Were autopsy findings
SCOL	sw requisites the second	Completed			performe		available prior to completion of cause of deeth?
Ä	nysician: The law nis cartificate has I director, page 2	ا ا			1 ☐ Yes	2 PNo	1 ☐ Yes 2 ☐ No
Vita	Physician: this cartificated rail director,	Be	25. Was case referred to medical examiner?		(Check only one))	
to	2 ≠ 2	P.	1		me 5 Residen 28d. Describe how	ce 6 Other (Sp	pecify)
ion	Attending For death. Sector: After by the funer	ation	1 ☑Naturel 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation M	njury at Work? I ☐ Yes 2 ☐ No	Edd. Describe flow	vinjury occurred	
Division of Vital Records,	al or Atte s after de il Directo ed in by ti	Certific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, offi building, etc. (Specify)	ce 2	28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by tha fi	edicai Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the basis of examination end/or investigation, in mention and manner stated.	e time, date and place, a ny opinion, death occurre	and due to the cau ed at the time, date	use(s) end menner e and place, and d	as stated. ue to the cause(s)
	Vithir To th cong			ense number	290	d. Date signed (Mo	
	7			UNT Ruya	P Ana e	Balto =	
				UNTRUGA	7 17	DAU 2	_141/
	Sta Registra	re.	31. Dete filed (Month, Day, Yeer) AUG 2 1 2007 AUG 2 1 2007				

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State of Maryland / Department of Health and Mental Hygiene

Joe Cephus Robertson

Joe Cephus Robert	1- For State Certification Cer	ficate of Death	Reg. No.
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Joe C. Robertson	2. Date of D Month August	eath Day Year 1644 hrs
	4a. Facility Name (if not institution, give street and number) 352 Earls Road	4b. City, Town, or Location of Death Middle River	4c. County of Death Baltimore County
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last	Months Days Hours Min	Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) WVA
nd show any nce.	1	own or Location Iiddle River	10d. Inside City Limits 1 Yes 2 X No
with the Maryland so 23a or 23a-f sho contified at once every rail Director	10e. Street and Number 3302 Gentian Lane	10f. Zip Code 2 1 2 2 0	10g. Citizen of What Country? USA
or iten	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No specify:	Specify: White
21215-0036 21215-0036 21215-0036 Meintal Pygiene. marked other than "natural"; cevent, the Medical Examiner. To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 th 17. Father's Name (First, Middle, Last)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self-employed 18.Mother's Name (First, Midd	16b. Kind of Business/Industry Truck Driver [e. Maiden Sumame)
1215-19 Per filed ental Hygent, the Be Co	Joseph C. Robertson	Esta Hall	c, margon bornamo,
D 2121 should be fil should be fil on marked natic event,	19a. Informant's Name/Relationship (Type, Print) Shirley Robertson	19b. Mailing Address (Street and Number or Rural Route	·
ore, M s I and 2 of Health if If item 2	20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State	3302 Gentian Lane Balace of Disposition (Name of cemetery, ematory or other place) The Ridge Memorial 8/22/	20c. Location - City or Town, State
Baltimore, permit. Pages I a Department of He Important: If ite injury or other tr	21. Signature of Fu teral Server License	22. Name and Address of Facility 300 Mac	ce Ave. Balto. MD
Physician /Medical	23a. Part I. Enter the disease, of complications that caused the death. I failure. List only one cause in each line.	Oo not enter the mode of dying, such as cardiac or respiratory	arrest, shock, or heart Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) Jue to (or as a consequence of):	17.6	
nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated		To Pales!
ecuted and - transit	events resulting in death) Last Due to (or as a consequence of): d.	· · · · · · · · · · · · · · · · · · ·	
60, ate be execu hysician an e burial - tr	UNPENDED		COL Data of delivers
Box 6876(e death certificate the attending phy ed for use as the b	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant in the Live birth 4 Pregnant at time of deal	2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
ords, P.O. Bover that the description is speen signed by the should be detached followed by the should be detached followed by Physical Ph	Part II. Other significant conditions contributing to death but not res		ves 2 No 3 Probably 4 Unknown
S & & C E		a	Vas an utopsy erformed? es 2 ✔ No 1 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No
Vital I ysician: his certifi director,	examiner?	26.Place of Death (Check only one) ER/Outpatient 3 DOA Other Nursing Home 5	Residence 6 Other: Scene
Division of Vital Rec Division of Vital Rec Within 24 hours after death. To the Finneral Director: After this certificate completely filled in by the funeral director, page	1 Ves 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 1 Accident Investigation		ibe how injury occurred iligate fell on Subject
Division of Division of To the Hospital or Attending I within 24 hours after death To the Funeral Director: After completely filled in by the furer ledical Certification:	3 Suicide 6 Could not be determined (Specify) Construction	or Tov	on (Street and Number or Rural Route Number, City vn, State) Road, Middle River, MD
To the Host within 24 host completely Medical C		e, death occurred at the time, date and place, and due to the d/or investigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	29b. Signature and fitte of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 18, 2007
6	30. Name and address of person who completed cause of death (Item 2 Susan Hogan MD. Assistant Medical Examiner	^{23a)} 111 Penn Street, Baltimore, MD 21201	
State Registra		back	
DHMH 17 Rev 1/2001		ORIGINAL	OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18, 2007 **Physician** 1:00 P M August Dorothy Marie Scheppske /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Villa Nursing Center Baltimore Catonsville 8. Date of Birth (Month, Day, Mar 10, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. Maryland 86 218-14-1111 Director Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a, State 10b. County Show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 1 North Morerick Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. In: If item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 【No Saltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert R. Kirby Ida Mossberger ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 North Morerick Avenue Catonsville, Richard C. Scheppske, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crestiawn
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition € = 10 6 = 10 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or 08/22/07 Marriottsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses MacNabb Funeral Home P.A.
301 Frederick Road Catonsville, Maryland 21228 Thomas Gregor Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Houte **Physician** Rena /Medical Due to (or as a consequence of): Examiner Atrial Fibrilled Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trai Due to (or as a consequence of): Physician/Medical the attending pl If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 ponths?
1 Yes 24 No 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certifical

autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2 NO

2□ No 1 Tyes

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

Avenue Sylle 203 Baltimore, Mod zizoq

DOUS3337

8/20107

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seay

2835 31. Date filed (Month, Day, Year) AUG 2 1 2007 32. Registrar's Signature

State Registrar

Be

2

Certification:

Medical

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:32 AM 15, 2007 August Elizabeth Emma Sulkowski /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** Days Hours 1 □ M 2 🕅 F 22, 1923 Pennsylvania 84 Director 189-12-8850 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 28a-f show 1 ☐ Yes 2 No ns 23a or 28a-f sh must be notified Director Harford Maryland Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 USA 310 Barclay Court 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify ģ 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 in and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) 12 Operator Telephone 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Mary Blakensop George Lenhart Malone ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 310 Barclay Court, Abingdon, Maryland 21009 Sandra Gilbert / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 Tremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 8-17-07 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee Russell Slig 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SKONA encephalopatty disease or condition resulting in death) /Medical Due to (or as a consequence of): 480 Examiner Pubeless electrical activity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last myocardial ischemija Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1☐ Yes 2☐ No 4 ☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown CHE Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Stypke Diabetes 24a. Was an perform rmed? 2 No CAD SI ALCO 25. Was case referred to medical examiner? or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of confine D 63420

State Registrar

31. Date filed (Month, Day,

Maryland 2121

Baltimore,

KOWSK

Division

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year!

AUG 2 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2:00 P. M 2007 **Physician** Norman Christopher Seidel August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Co. 502 Barnside Place Bel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Maryland 78 212-26-0360 10,1929 Director Aug. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mines in any longe. 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State 1 ☐Yes 2X No Director Harford County Bel Air Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number United States / 21015 502 Barnside Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b, Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Fastern Stainless Steel College (1-4or 5+) Elementary/Secondary (0-12) Manager N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida B. Helmbold Christocher J. Seidel 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 502 Barnside Place, Bel Air, Maryland 21015 Mrs. Ethel Seidel (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State Evans Funeral Chapel August 21,2007 Forest Hill, MD 22. Name and Address of Facility

Evans Funeral Chapel & Cremation Services - Bel Air 21. Signature-of Funeral Service License 3 Newport Drive Forest Hill, Maryland 21050 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatsc Cancer 22 months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examine The law requires that the death certificate be executed physician and sthe burial-trans resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 1 Yes 2 ☑ 2 No certificate To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be (25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check one) 29c. License number 045390 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

and title of certifier

29b. Signati

32 Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Myo Min (h. D.) CO2 South Atwood Road # 200, Bel Air, no 21014

Angust 20th, 2007

O. Box 68760,
Records, P.
Division or Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Terra Simmons 3:50 A M AUGUST 15 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MOSP 1719 L BALTIMORE GOOD SAMARITAN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-9-1974 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F 32 Md. 217-94-2521 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show iral", or Items 23a or 28a-f shor Examiner must be notified at Yes 2□No Md. NA Baltimore Director the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 6540 Falkirk Rd. 21239 USA Funeral death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Black 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 9th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lloyd Simmons Sylvia Wells 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other trau 6540 Falkirk Rd. Apt. C, Baltimore, Md. Sylvia Wells Mother 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-18-07 Greenmount Cem. Baltimore, Md. 22. Name and Address of Facility 21. Signature Funeral Service Licensee March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 23a. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I media e Cause (Final diseas' or condition r swiling in death) SEPSIS Physician /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate aftending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed certificate has 1 Yes 2 No Hospital or Attending Physician: Tleathours after death.
Funeral Director: After this certificate itely filled in by the funeral director, par 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral C completely filled i Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD RES-000 0 anny 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD LOCH PAVEN BWD, BALTIMORE, 5601 SOMNATH _ GHOS.H 32. Figistrar's Signature th Day, Year) AUG 2

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Smalls Samuel 6 /Medical 4c. County of Death 4b. City, Town, or Location of Death Eacility Name (If not institution, give street and number) Examiner NA BALTIMORE IN Under 24 Hrs. SAMARITAN HOSPITAL 7. Ige (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** Min Months Hours 1 XM 2 ☐ F 250-70-7626 12-8-1940 Director 66 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1√2 Yes 2 No r 28a-f sh notified Director Baltimore Md. NA 10g. Citizen of What Country? 10e. Street and Number ns 23a or 7 must be n 21201 USA 815 W. Saratoga Street Apt. 10 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 'natural', or Items dical Examiner mu Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Black 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Smalls, Samue Elementary/Secondary (0-12) College (1-4or 5+) **VARIOUS** 12th grade Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgie Lillie ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 912 Ashbridge Dr. Apt. D, Baltimore, Md. 21221 Judy Woods Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Mem. Pk. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of I Important: If its any injury or o once. 8-22-07 Randallstown, Md. Øonation 5 ☐ Other (Specify) 2. Name and Address of Facility 21. Sy nature of Funeral Service Licensee March F.H. East 1101 E. North Avenue, Baltimore, Md. 21202 Pag1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, mediate Cause (Final sease or condition sulting in death) Physician respiratory Acute /Medical Due to (or as a consequence of): **Examiner** obstruction Airway Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse uence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Aspiration prelimonia 1 ☐ Yes 2 ☐ No 3 Probably Malnutrition 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform colitis Schemic 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3 DOA 1 Yes 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director; 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29d. Date signed (Month, Day, Year)

State Registrar

parna 31. Date filed (Month, Day, Year) AUG 2

Jonnal

29b. Signature and title of certifier

5601 Loch Raven Boulevard, Baltimore, MD 21239 , m.D. 32. Fegistrar's Signature

m.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0062735

August, 16, 2007

DHMH 17 Rev 1/2001

permit. Pages 1 Department of H Important: If Itel any Injury or otl **Physician** /Medical **Examiner**

death with the Maryland

1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", or ite

Health a

other!

altimore, Maryland 21215-0036

physician and is the burial-trans as ed by the a cate has been signed I

The law requires that the death certificate be executed the Hospital or Attending Physician; funeral director, death. 24 hours a

Division or Vital Records, P.O. Box 68760,

State Registrar

10d. Inside City Limits 1 Yes 2 No Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 2 3 Noticed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk State of Maryland <u> 12th</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wayne Daniels Lucile Oats ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ruth Honnas /daughter 27 Yew Road Baltimore MD 21221 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Holly Hill Cemetery 8/20/07 Baltimore MD 1 Burial 2 □ Cremation 4 □ Denation 5 □ Other (3 □Removal from State 5 Checify) 22. Name and Address of Facility 300 Mace Ave Balto. MD 21. Signature of June 14 Pervi Licensee Connelly Funeral Home of Essex 21221 etions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Enter the disease or compleshock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) in Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√10 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Lecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

BaHO., MD. 2/22/

30. Name and address of person ho completed cause of death (Item 23a) (Type, Print)

2007

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 14, 2007 **Physician** 1335 Donald Boutwell Smith August /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1⊠M 2□F March 15, 1927 Massachusetts 80 Director 015-20-8872 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1∰Yes 2□No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 United States 199 Rollins Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 MYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 ☐ Widowed 4 🖾 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) U.S. Government Civil Servant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harriet Grace Miner 2 Allen C. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20708 14238 Greenview Drive, Laurel, MD Jennifer Anne Smith / Daughter Date 23 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition y Crematorium 2007 Bethesda, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 August 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Montgomery Crematorium 21. Signature of Funeral Service Licensee M01473 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Anoxic brain injury Physician /Medical Due to (or as a consequence of): 3-4 days Examiner Respiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Anspiration the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of 28d. Describe how injury occurred

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

in 24 hours after the Funeral Director: After Funeral Director: After funeral filled in by the f

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide 4 ☐ Homicide

(Check only one)

29a. Certifier

5 ☐ Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 TYes 2 No

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

066066

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Suburban Tospital Suburban

Andrew Wong, no 8600 Old Georgetown Rd Bethesda, MD

20514

State Registrar 31. Date filed (Month, Day, Year) 2007 AUG 2 1

32 Aegistrar's Signature

within 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Dorothy M. Saukko August 16, 2007 9:15 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Heritage Nursing Center Dunda1k 5. Social Security Number 219–07–0385 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 □ M 2 🕱 F 86 March 31,1921 Maryland Director Usual Residence of Decedent 10b. County N/A death with the Maryland 10c. City, Town or Location 10d Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore 1XYes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6917 Conley Street 21224 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examiner. once. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Adler Julia Grutkowska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6917 Conley Street Baltimore, MD 21224 Toivo E. Saukko- Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 St Burial 2 □ Cremation 3 □ Removal from State Sacred Heart of Jesus 8/18/2007 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Charles S. Zeiler & Son Inc. 21. Signature of Funeral Service Licensee 6224 Eastern Avenue Baltimore, MD 21224 23a. Parti Enter the dilease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List on, one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that be increase or injury) Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician end s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has e 2 s autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760, within 24 hours after con-

> State Registrar

29b. Signature

31. Date filed (Month, Day,

AUG

30. Nam

trutem 23a) (Type, Brint)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 2007 **Physician** 7:00 а м Martha Mary Sullens /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Carrol1 Finksburg Bonds Forrest Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. March 24, 1921 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 ☐ F Maryland 86 212-12-7013 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hyglene. Important: if them 27 is marked other than "natural", or thems 23a or 28a-f show any injury or other traumatic event, the Medical Examinating indiffied at once. 1 ☐ Yes 2 → No Director Carrol1 Finksburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21048 USA 2261 Old Westminster Pike 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 25 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha M. Patanowski Frank Stump 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Fallston, MD 21047 2105 Appaloosa Dr Thomas Sullens-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 8/16/07 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 21. Signature of Funeral Service Licensee 6415 Belair Rd Baltimore, MD 21206 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onser and Death Immediate Cause (Final disease or condition resulting in death) 10 (Brotz with **Physician** /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) ned by the 9☐ Unknown 9 Unknown been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sl autopsy 200 No 1 ☐ Yes 2 ☐ No Yes : After this certifications a funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 4 Nursing Home 5 Residence 6 Nother (Specify) HOFM 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27 Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. i Director: 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours after To the Funeral Dire Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ress of person who completed cause of death (Item 23a) (Type, Print) BAZTIMORO BLUD; ANKRONKY UND 21048 MATHOW Megistrar's Signature AUG 2 1 31. Date liled State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Edith **Physician** Month 0830 2007 /Medical 1 ugust 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Augsburg Lutheran Home Baltimore Baltimore Co. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number **Funeral** 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Oct. 01, 1915 San Antonio, TX. 1 □ M 2 🖼 F 91 Yrs Director 212-01-6546 Usual Residence of Decedent 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show or items 23a or 28a-f shov miner must be notified at Director Maryland Baltimore Co. 1 ☐ Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? s 1 and 2 should be filed within 72 hours after death with of Heath and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be nother traumatic event, the Medical Examiner must be nother traumatic event, the Medical Examiner must be not a content of the properties of 6811 Campfield Road 21207 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐**M**No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify Completed by Specify: 3 □ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Klauenberg Martha Clara Hepner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances B. Schweizer(Dau.) 14 Betty Bush Lane Baltimore, MD. 21212 permit. Pages 1 a Department of He Important: If Item any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Aug.20, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State lug.2 2007 Dulaney Valley Mem. Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens eaceful Alternatives Funeral&Cremation, 2325 York Road Timonium,MD 21093 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hharasclevatic disease or condition resulting in death) cenebral Vascula 1600 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a I Yes 2 No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2☑No 3☐ Probably 4☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 212 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this s after death. I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-A Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, or Attending Physician; within 24 hours a llled the Hospital

> State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who co

Year)

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cause of death (Item 23a) (Type, Print)

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38 Registrar's Signature

and manner stated.

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12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

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DR. D (MAN E) Store 31. Date filed (Month, Day, Year) 22. Registrar's Signature	F ≥ 5 8	-			B		D-	4052	.1		Augu	st 16,	2007		
DR. D (MAN E) Store 31. Date filed (Month, Day, Year) 22. Registrar's Signature			No November 1								- 6				
DR. D (MAN E) Store 31. Date filed (Month, Day, Year) 22. Registrar's Signature	. ^				use of death (Item 23a)	(Туре	, Print) 3 Vo	KOZ	117	AL -	DKIV	- 3m	175 Z	NA	
State 31. Date filed (Month, Day, Year) 22. Registrar's Signature	10		DR. OCHANES QUEN BURNIE, MD 21061												
	S	ate	31. Date filed (Month, Day, Yea	r) 2	. Registrar's Signature	-	-								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 17 **Physician** 2007 12:40 pM Donald E. Wheatley August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 13020 Laurel-Bowie Road Laurel 8. Date of Birth (Month, Day, 6. Sex 11 M 2 F If Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Min Yrs. 148-42-3597 51 JAN 05 1956 New Jersey Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mentai Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 1 ☐ Yes Ž No Director MD Prince George's Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13020 Laurel-Bowie Road, Apt. 301 20708 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 76-80 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No Specify. þ 3 ☐ Widowed 4 No Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Computer Technician Computer 7 Is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental h Be Charles Wheatley Deloris Marie Newmeyer ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: if item 27 Is any injury or other trau once. Sharon Davis - daughter 1308 Kingsway Court, Yukon, OK Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 8/21/2007 Baltimore, MD 21. Signature of Funeral Service Licensee H ²² Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervai Betw Onset and Death immediate Cause (Final disease or condition resulting in death) Myocardin **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, nding physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Registrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per dyr 8870 8-21-07 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First Middle, Last) **Physician** /Medical 4b. City, Town, or Location of Death ne (If not institution, give street and number) **Examiner** Prince Georges Morning side Nursing Home Laurel Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Min. Months Davs Hours 1 □ M 2**K** F Washington, D.C. 84 July 15, 1923 579-20-6941 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Laurel Maryland Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States America 7700 Cherry Lane 20707 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: White Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harold Watts Cecil Taylor 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9276 Cherry Lane #84 Laure1, MD 20708 Shirley R. Lippincott/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition ⑤ ☐ Other (Specify) Cedar Hill 8/10/2007 Suitland, Maryland 22. Name and Address of Facility 21. Signature of Fyneral Service Licensee Man E willi-Fleck Funeral Home 7601 Sandy Spring Road Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequer Examine attending physician and for use as the bunel-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐NO the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?"

1 Yes 2 No 24a. Was an autopsy this certificate 1 Yes 2 1 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 1 Yes 2 No 2 ER/Outpatient 3□ DOA 1 Inpatient 2 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral 28a. Date of Injury 27. Manner of Death Certification: Director: After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

The law requires that the death certificate be execute

Division or Vital Records, P.O. Box 68760

31. Date filed (Month, Day,

Registrar's Signature

run 321 /1 mce

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marviahu7, Des Film 687 On Mealth and Wiental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 11:20pm^M 18, August DARBARA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Min Months Days Hours 1□ M 2 🗗 🕇 213-34-3885 MARYIAND Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No BALTIMORE Directo UTHERVILLE MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 20 MARGATE USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2 No Yes, Give 1 □ Never Married 2 □ Married 1 ☐ Yes 2 1 No Specify: WHITE Specify: ģ 3 ☐ Widowed 4 N Divorced Year or Dates: Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SECRETARY MARYLAND 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Luther Hood MILDRED HCHARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) UTHERVILLE, MO MARGATE KICHARD EAGL 20b. Place of Disposition (Name of cemetery, crematory or other place)

LAKE VIEW PARK 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2007 Sykesuille, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility IVES FUNGRAL & CREMATION CIR. 1.A. 21. Signatur of Funeral Service Licenses TIMOULUM MO 21093 RD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 ☐Ectopic pregnancy
5 ☐ Other (specify) Month Day Year 4☐Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by director, page 2 should be 3 Probably 4 Unknown 1 ☐ Yes this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 1 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 100 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred filled in by the funeral 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident l or Attend after death Director; 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier n30. Name and address of person who completed cause of death em 23a) (Type, Print) CHIMITS ST 670 M MM MD Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 2 1 2007

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs Months Days Hours Min.

Frederick

Waters

7. Age (In yrs. last birthday)

77

3. Time of Death

11:45 PMM

9. Birthplace (State or Foreign

Maryland

August 14 Day

8. Date of Birth (Month, Day, Y NOV 16,

2007 ear

4c. County of Death

Year) 1929

Frederick

		Physic /Med Exami	ica
İ		uneral irector	
	e Maryland	la-f show tified at	roto

Ardis

5. Social Security Number

Usual Residence of Decedent

212-24-3793

4a. Facility Name (If not institution, give street and number)

J.

1 □ M 2 □ √F

Northampton Manor Nursing Home

6. Sex

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed 12

Division or Vital Records, P.O. Box 68760,

Maryland Frodorick									
3 Liar yrand rrederick	j Maryland Frederick Frederick 1□Yes 2XNo								
Maryland Frederick 10e. Street and Number 6107 Fulmer Road		10f. Zip Code 21703	10g. Citizen of What Co	ountry?					
Armed	S X2(No Give	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer I ☐ Yes 2☐ No <i>Specify:</i>	Specify Yes or No- to Rican, etc.) 14. Race - Am Black, Whi SpecifyWhi	te, etc.					
15. Decedent's Education (Specify only highest grade complete.	16a, Deced	lent's Usual Occupation	16b. Kind of Business	16b. Kind of Business/Industry					
	(1-40r5+)	kind of work done during most of wo DO NOT use retired) emaker	Own Home	Own Home					
17. Father's Name (First, Middle, Last)]		me (First, Middle, Maiden Surname)						
Scott Luther Study		Roma	Markoe						
19a. Informant's Name/Relationship (Type. Print) Franklin G. Waters, Jr		- · · · · · · · · · · · · · · · · · · ·	ural Route Number, City or Town, State,						
20a. Method of Disposition	20b. Place of Dispo		Date 20c. Location - City or						
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro	m State Mount OLiv	et Cemetery Aug. 17	, 2007 Frederick	, Marylan					
21. Signature of Foreral Service Licensie	M00255 1	Keeney and Basfor 106 East Church S	d PA Funeral Home t., Frederick, MD	21701					
23a. Part1. Enter the disease, or complication. That shock, or heart failure. List only one call e or	t caused the death. Do not ent	er the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between					
immediate Cause (Final disease or condition resulting in death)	acente	Demestia		Onset and Death					
Due t	o (or as a consequence of):	Lunion							
Sequentially list conditions, b.	o (or as a nonsequence of):	regiona							
Sequentially list conditions, it any beautiful to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
resulting in death) Last Due to (or as a consequence of): d.									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown Part II. Other significant conditions contributing to Type III.									
23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1									
Part Ii. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death					
Hypertension			1 ☐ Yes 2 ☐ Mo 3 ☐ P	robably 4 □Unkn					
//			24a. Was an 24b. Were a	utopsy findings avail completion of cause					
			autopsy prior to death? 1 Yes 2 No 1 Yes	1.2					
25. Was case referred to medical		26. Place of De	ath (Check only one)	2 2 2 110					
examiner? 1 Yes 2 No Hospital: 1	☐ Inpatient 2 ☐ ER/Outpatien	t 3 DOA Other: 4 Nursing I	Home 5 ☐ Residence 6 ☐ Other (Spe	ecify)					
	te of Injury 28b. Time of Injury Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred						
3 Suicide 6 Could not be 28e, Pla	ce of injury - At home, farm, str Iding, etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Street and Number or Fi City or Town, State)	lural Route Number,					
29a. Certifier 1 Certifying Physician: To (Check only one) 1 Medical Examiner: On the and m			Dee, and due to the cause(s) and manner a curred at the time, date and place, and du						
29b. Signature and title of certifier	and	29c. License number	29d. Date signed (Mon	th, Day, Year)					
Hap	mo.	D 54636	August 15	, 2007					
7				-					
30. Name and address of person who completed can Syed W. Haque, M.D.,			ick MD 21701	<u>-</u>					

DHMH 17 Rev 1/2001

Registrar

Amend Item 21 State of Maryland / Department of Health and Mental Hygiene Th, 8870,08/21/0/dhb Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 10 Year **Physician** Dosoth Wenner 2.13 AH. 200 web /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of Overlea **Baltimore** If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1□ M 2₩ F Months 72. Director 212-38-1299 02/26/1935 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23a ~ " - any injury or other treumstic event. It is any injury or other treumstic event. 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location Director ¥ Yes 2 No MD Baltimore City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6116 Belair Rd 21206 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No 1 ☐ Yas 2 ☐ No Specify: Specify: White Completed by 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unk ımk ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassandra Lucas, Caseworker 10 N. Calvert St., #300 Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Carmel Cemetery 07/12/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Skarda Funeral Home, 2829 Hudson St., Balto., MD Timothy S. Harman per DVR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Coronari Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) whoy Division of Vital Records, P.O. Box 68760 The law requires that the death certificate be Physician/Medical Due to (or as a consequence of) as use for signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Lement þ should 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 certificate has 200No 1 ☐ Yes 2 No 1 ☐ Yes Attending Physician: ar death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 ursing Home 5 Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Natural
2 Accident 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 August 141 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Rd - 21239 22. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 2 1 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Rosalie В. Whalen 14, 2007 2105 August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Hospital Belair HArford If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 ☐ M 2 ☐ XF 216-36-5200 68 Dec.27,1938 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Harford Belair 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Sunflower Drive 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Brune Sr. Anna Virginia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas H. Whalen Jr. 786 Summerhill Drive Laverbne. Tenn. 37086 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Bayview Crematory 8/20/07 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fungral Service Licensee 300 Mace Ave.Balto. MD Connelly Funeral Home of Essex 21221 23a. Park. Enter the diseal corresponding to the cause of death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Immediate Cause (Final Ventricular fibrillation disease or condition resulting in death) Due to (or as a consequence of): 48 hrs Acute myocardial interction Sequentiary ist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23d. Date of delivery

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

show

ral", or items 23a or 28a-f shor Examiner must be notified at

"natural",

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 Is marked other any Injury or other traumatic event. If

the Medical

315 M 800 266913 Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

Be

Examine Physician/Medical Completed

as the burial-transit been signed by the attending physician should be detached for use as the buria To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, Be P Certification:

Records, P.O. Box 68760,

Vital

Division or

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 ☐ Ectopic pregnancy 4☐Pregnant at time of death 9□Unknown

5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death?

Month

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated.

Hortic value replacement Coronary arreny disease

COPD

Hospital:

24a. Was an autopsy performed? Yes 2 No 1 Yes 26. Place of Death Check onl one

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♣ No

Day

Year

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

mpleted cause of death (Item 23a) (Type, Print)

M D 5 CK Registrar's Signature

State Registrar

eg. No. (, U) (, U)
th 3. Time of Death
Day Year 6:20 AM
4c. County of Death
Year) 9. Birthplace (State or Foreign Country)
1932 Pennsylvania
10d. Inside City Limits
1, ☐ Yes 2 ☐ No
Og. Citizen of What Country?
United States America 14. Race - American Indian,
Black, White, etc.
Specify: White
16b. Kind of Business/Industry
Police Department
Maiden Surname)
r, City or Town, State, Zip Code)
and 20708 20c. Location - City or Town, State
Education - Only of Town, State
Laurel, MD
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2 YEARS
23d. Date of delivery Month Day Year
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h with t	3a or 2 st be n	al Dir	3328 Summit Aven	ue		10f. Zip Code 2123		1	0g. Citizen o USA	or what Cou	ntry?			
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Maryland 21215-0036	d other d other event, tl	Be	17. Father's Name (First, Middle, Last)		'			ne (First, Middle, i	Maiden Surn	ame)				
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Baltimore, permit. Pages 1 ar	Department of Hes Important: If item any injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		EVANS & CREM	Disposition (Name of process) LUNERAL CHATION SER		21, 2007		Hill,M	aryland			
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n Or 19 Phy	fter this neral d	n: To	27. Manner of Death 12 Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	28b. T	ime of 28c. Ir	jury at //ork?	ome 5 Boside 28d. Describe he			ny)			
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DIV	within 24 hours aff To the Funeral D completely filled ir	Medical Co	29a. Certifier (Check only one)	ysician: To the best of r niner: On the basis of ex and manner stated	amination and							(s)		
To th	To th	Me	29b. Signature and title of certifier			29c. Lice	ense number	^ 2	29d. Date sig		, Day, Year)			
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36	Funeral Director		5. Social Security 1 359-40	-9141 ¹□	7. Ag	e (In yrs. 56	last birthday Yrs.	Months	er 1 Year Days	Hours Min.	8. Date of (Month)	Birth Day, Ye.	51	9. Birthp Coun Conr	lace (State or Foreign try) ecticut
is facine	and w		Usual Residence of 10a. State	of Decedent 10b. County		10c. City	y, Town or L	ocation		_				1	0d. Inside City Limits
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1	r 28a	irec	10e. Street and Nu	umber				10f. Z	ip Code			10g.	Citizen of Wh	at Coun	try?
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to ME 0/208	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1	rried 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 1 If Yes, Give Year or Dates:		S. 13			Hispanic Origin? (Sean, Mexican, Puer Specify:	Specify Yes or to Rican, etc.	r No-	14. Race Black, Specify:	White,	
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7	/Medical Examiner		resulting in death)		Due to (or as										
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- 4	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be	28e. Place of inj building, et	iury - At he to. <i>(Specil</i>	ome, farm, s fy)	treet, facto	ory, office		28f. Locati City o	on (Stree r Town, S	t and Numbe state)	r or Rura	al Route Number,
Atrood, Divin	Hospital 24 hours a Funeral I etely filled	Medical C	29a. Certifier (Check only one)	1X Certifying Phys 2 Medical Exami	sician: To the best ner: On the basis of and manner st	of examina	owledge, deation and/or	ath occurre investigati	ed at the t	ime, date and plac opinion, death oc	ce, and due to curred at the t	the caus ime, date	se(s) and mar and place, a	ner as s	tated. o the cause(s)
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	1	1	30. Name and add	dress of person with a	mpleted cause	de th (Iter	n 23a) (Type	e, Print)		- 0) 10		4 -4	J		
_	at.			Nourani		860	0 010	d Geo	orge	town Ro	. Bet	hes	da, Mo	3 20	0814
	St	ate	31. Date filed (Mo	onth, Day, Year)	32. Registi	rar's Signa		marke	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 21333 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Hulen В. 03, 2007 <u>22:</u>45₽ [™] Brown Auq. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 14A Deborah Court Elkton Cecil If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 10 M 2□ F Yrs. 232-78-7105 58 Director /22/1948 W. Virginia Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits ₩oue rthen "naturel", or iteme 23e or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 🖾 No MD Cecil Elkton Direct 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 14A Deborah Court 21921 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours efter 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ል 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Heelth and Mental Hyglen. Important: if item 27 is marked other the eny injury or other traumatic event, the ADRE. 12 Fork Lift Operator Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dennis Brown <u>Pebble Jarrell</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Lee Workman - niece 14A Deborah Court, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cherry Hil Cemetery 8/8/07 Elkton, MD 21. Signature of Funeral Service Licensee CC0442 22. Name and Address of Facility Beeson Funeral Home of Newark 2053 Pulaski Highway, Newark, DF 19702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires thet the deeth certificate be executed attanding physicien end for use es the buriei-tren Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2.☐No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | EP/Outpatient 3 | DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No ၉ this After th funerei 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. 1 Director: A d in by the fo investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide efter within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ş 29b. Signature and tille Centifier 29c. License number 29d, Date signed (Month, Dav. Year) ٥

5 State

31. Date filed (Month, Day, Year)

AUG 7, 2007

Robert Wisniewski

MD - 5610 Kirkwood Highway, Wilmingtn, DE 19808
39. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

AMEND TIFW/26 per/APB (870, 8/21/07 US) State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** HOWARD L. BURCHETTE 12:01P M August 2007 12 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3402 Cedar Church Road Darlington Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 10/21/1915 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1**7** M 2□ F 91 North Carolina Yrs Director 240-28-3790 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rthen "natural", or iteme 23a or 28e-f show the Medical Examiner must be notified at MD Harford 1 Yes 2 No Director Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3402 Cedar Church Road 21034 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene ant: If Item 27 is marked other then ury or other treumetic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maston Burchette Drucie McMeans ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patsy Poole/Daughter 337 Catherine Street, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 DBurial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If eny injury or once. Darlington Cemetery 8/15/2007 Darlington, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 23d. Bent1. Sold the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** WEEKS ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy õ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be SENILE BERENTIA 1 Yes 2 No 3 Probably 4 Unknown Be Completed MAL NUTRITION 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No R/Outpatient Certification: To 3FT DOA this 28a. Date of Injury (Month, Day Year) 27. Mannar eath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 24 hours after death. 1 TYes 2 No М 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MITTENDING 2007 D0021207 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 FRANZ VELLA-CAMILLERI, M.D. 5 MIDCREST CT., BALTIMORE MD 21286 C. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 1 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Betty Jane Bobbitt 2007 August 6 22:08 PM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Union Hospital of Cecil
Social Security Number 6. Sex County
7. Age (In yrs. last birthday) Elkton Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 6, 1933 Birthplace (State or Foreign Country) Months Days 1 □ M 2 1 F Hours Min. 219-30-4282 74 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2564 Biggs Highway 21901 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 21☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes ŽŒNo Specify: 3€CXWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Warren Guthrie Iva Bolen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Strime1 / Nephew 590 Aiken Avenue, Perryville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State

HOSPITAL, ELIKTON

Physician /Medical Examiner

requires that the death certificate be executed

Physician

/Medical

Examiner

10a. State

Director

Funeral

à

Completed

Be 2

Funeral

Director

72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

the burial-tra attending physician as nse ρ signed by the a has lee 2 s page certificate After within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Division or Vital Records, P.O. Box 68760.

the Hospital or Attending Physician:

3

	1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro	emoval from State cemetery	, crematory or other place)	August		
	4 □ Donation 5 □ Other (Specify)	Mayerd	ale Crematory	7, 2007	Newark Dela	ware
	21. Signature of the all Section Liver.		22. Name and Address of Fa	^{cility} Crouch Fu	neral Home	
	1 porter (sex	2.0%		n Street, No		ryland 2190
	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do no e cause on each line.	ot enter the mode of dying, such	as cardiac or respiratory a	arrest,	Approximate Interval Between
	Immediate Cause (Final disease or condition	Presidente	a Souther 2	Ober		Onset and Death
	resulting in death)	Due to (or as a consequence of	0:\	V	0	((()
	Sequentially list conditions, b				411-	
ner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consecution of):			
Ē	that initiated events					
Ä	resulting in death) Last	Due to (or as a consequence of):			
ical	d	1				
led						
1	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death	2 DEstania nuasana au		23d. Date of deli	very
icia	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant at time of death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
hys	9 □ Unknown	9□Unknown				
V P	Part II. Other significant conditions con	tributing to death but not resulting in t	the underlying cause given in Pa	rt I. 23e. Did	tobacco use contribute to	the cause of death?
Completed by Physician/Medical Examiner	Acute aence	ferling, he	mer 14 clim	<u>en</u> 10	Yes 2 No 3 Pro	obably 4 Donknown
lete	From miles	- h	- It i - aid:	c 24a. Was	an 24b. Were au	topsy findings available
Ē	- Dysmolth)	in, my	DIR GOVERN	auto	psy prior to coormed? death?	ompletion of cause of
ပ္ပ	25. Was case referred to medical	mia.		1□ Yes	2v21No 1 □ Yes	2 DV0
Be	examiner?	ospital:	Othori	ace of Death (Check only		
P	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 ☑ Inpatient 2 ☐ ER/Outp 28a. Date of Injury 28b. Tir	70	Nursing Home 5 ☐ Res		cify)
ou	U Natural 5 ☐ Pending		ury Work?		how injury occurred	
cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	00 00	M 1 □ Yes 2			
ŧ	4 ☐ Homicide determined	28e. Place of injury - At home, farm building, etc. (Specify)	n, street, factory, office		(Street and Number or Ru wn, State)	ral Route Number,
ပ္ပ				14		
Medical Certification: To	(Check only 2 Medical Examin	ician: To the best of my knowledge, ner: On the basis of examination and	death occurred at the time, date or investigation, in my opinion,	and place, and due to the death occurred at the time	cause(s) and manner as , date and place, and due	stated. to the cause(s)
Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License numbe	er I	20d Date signed /##s=#	Day Your
	A A Signature and the or certifier			3730	29d. Date signed (Month	i, Day, Tearj
	VIP	111	10 2006	3.00	8/6/0	7

State

Registrar

UNION

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

NAMITA 31. Date filed (Month, Day, Year)

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			for State Registrar	Otato of Mi	Ce	ertificate of			eg. No.						
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	Physici /Medio		Ronald Shephard	l Briones				August	3 2007						
	Examir	er	4a. Facility Name (If not institution, give	· · · · · · · · · · · · · · · · · · ·			or Location of Death		4c. County of Dea	th					
		g 7	Union Hospital of 5. Social Security Number 6. S			E1kt		8. Date of Birth	Cecil	Mariana (04.4 17					
Ü	Funeral Director	ij		ex 7. Ag	e (In yrs. last birthda 74 Yrs.	Months Days	Hours Min.	(Month, Day,	9, 1932 Wa	thplace (State or Foreign ountry) shington					
	land ow at		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits					
	Mary Fied a	ţō	Maryland Cecil		North Ea	st				1 ☐ Yes 2 📉 No					
	h the r 28a r noti	irec	10e. Street and Number		I	10f. Zip Code		1	0g. Citizen of What C	ountry?					
	th wit	a	162 Irishtown Roa	ad		21901		U	nited Stat	es					
	r dea	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	B. Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi						
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Ď	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	f XX Yes 2 □ f If Yes, Give Year or Dates:	∾Army 1953-73	1 □ Yes ② QNo			Specify: Wh						
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Maryland	shoul nd M marl	F	19a. Informant's Name/Relationship (Type. Print)	19b. Ma	iling Address (Street	1		City or Town, State,	Zip Code)					
Š	alth a 27 is 27 is r trat		Nancy Smith Brio	nes / Wife	162	Irishtown	Road, No	rth East	, Maryland	21901					
ore,	of He	-	20a. Method of Disposition	D	20b. Place of Dis	position (Name of rematory or other pla	ce) Augu	Date S t	20c. Location - City or	Town, State					
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Baltimore	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natuu any Injury or other traumatic event, the Medical once.		21. Signature of Funeral Service Licen	666		22. Name and Addre	٠ ر.		neral Home	ary1and21901					
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Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ð	Part II. Other significant conditions	ontributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.	1 □ Ye	oacco use contribute t es 2 <mark>∏ N</mark> o 3 □ P	robably 4 Unknown					
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/ita	hysician: The law his certificate has t Il director, page 2 s	Be (25. Was case referred to medical examiner?					th (Check only on	e)						
or Vital	Physician: this certificanal director, participans	은	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatie		ent oll box			ence 6 Other (Spe	ecify)					
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Division	death death ctor: y the	licat	3 Suicide 6 Could not be	28e, Place of init	ury - At home, farm, :		1103 2 110	28f, Location (St	reet and Number or F	'ural Route Number.					
Θ	afor A after Dire	ertil	4 Homicide	building, et	c. (Specify)			City or Towr	ı, State)						
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical Certification:	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	f examination and/or	ath occurred at the tinvestigation, in my	ime, date and place opinion, death occu	, and due to the carred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)					
	ro the within ro the comple	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mon	th, Day, Year)					
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			30. Name and address of person who	completed ause of d	eath (Item 23a) (Typ	e, Print)	- / 6 4		3 1						
	154 LVA		Dr. Rolando Najera	, 138 Cat	hedral St	reet, Elkt	on, Mary	land 21	921						
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	docute!									
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			1 - For State Registrar	State of M	laryland		irtment of I tificate of		l Mental Hy	giene Reg. No.	- T	
	Physici		1. Decedent's Name (First, Midd LAWRENCE VINCE)	•	•				2. Date of De Month AUGUST	Day) 007	3. Time of Death 2:15 PM
	/Medic Examin		4a. Facility Name (If not institution CHARLOTTE HALL					or Location of De		4c. County of		3
	uneral irector		5. Social Security Number 229–09–5103		ge (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days			th Year) 4, 1913	9. Birthp	place (State or Foreign
Maryland	fahow	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND CHAR			Town or Lo					1	0d. Inside City Limits
h with the	s 23a or 28a-f show wat be notified at	Funeral Directo	10e. Street and Number 201 A ELLERBE	DRIVE			10f. Zip Code 206	40	AN A	10g. Citizen of W		
. I. Z. I. SUUSO within 72 hours after death with the Maryland ene.	iten 27 is marked other than "natural", or Itams 23e other traumatic event, the Mudical Examinational towart.	by	11. Marital Status 1 □ Never Married 2 Mar 3 □ Widowed 4 □ Divorces	If Yas Give	[?] № 194 5	- t	Vas Decedent of I i Yes, specify Cub	an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK		
	other than "nati	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 9TH GRADE	nt's Education est grade completed) Collège (1-4or	5+)	(Give life. [lent's Usual Occuj kind of work done OO NOT use retire	during most of ward) -	vorking	16b. Kind of Bus		
Should be filed	marked other	To Be C	17. Father's Name (First, Middle, AUGUSTUS BROWN					18. Mother's N	ame (First, Middle, BROWN	Maiden Sumame	9)	
~ ~ ~	lem 27 Is ma other trauma		19a. Informant's Name/Relations CYNTHIA BROWN			6005	NAVAL AV		NHAM, MA		State, Zip 2070	-
S to			20a. Method of Disposition 1 Surial 2 Cremation 4 Donation 5 Other (5		cen	netery, crem	sition (Name of natory or other pla		Date IST 14, 2007	20c. Location - (
permit Depart	Important: If any injury or poce.		1. Strature of Functal Service LYDIA C. THORNI	The fire	0583	22 T	Name and Addre HORNTON 439 LIVI	FUNERAL NGSTON F	HOME, P.	A IAN HEAD	, MA	RYLAND 2064
/M	physicien and edical strength aminer	ai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									Approximate Interval Between Onset and Death
	been signed by the attending phy: should be detached for use as the	d.								23d. Date Mon		ery Day Year
quires thet t	been signed by should be detac	þ	Part II. Other significant conditi	ions contributing to death t	but not result	ing in the ur	nderlying cause gr	ven in Part I.				ne cause of death?
The law re	icete has beer, page 2 sho	Completed								osy promed?	Vere auto rior to cor eath?	psy findings available mpletion of cause of
UNISION OF VICE THE COLORS, F.O. DOX Of the Hospital or Attending Physician: The law requires that the death certifulial 24 hours after death.	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification: To Be	3 ☐ Suicide 6 ☐ Could	Hospital: 1 □ Inpatii ing tigation d not be larger 28e. Ptace of Injury	ury 2 ay Year)	R/Outpatien 28b. Time of Injury	28c. Inju Wo	her: 4 Nursing ny at nrk? Yes 2 No		dence 6 Othe	bd	
Hospital 24 hours a	Funeral letely filled	Medical Ce	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ing Physician: To the best If Examiner: On the basis of and manner st	of examinatio	ledge, death on and/or inv	occurred at the ti	ime, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and mar date and place, a	ner as st	ated. the cause(s)
To the	To the		29b. Signature and titte of certific			23a) (Tyne 1	29c. Licens	1978	A	29d. Date signed 8 - 7	(Month,	Day, Year) 207 AN 20716
DB	ا Sta	te	30. Name and address of person Nedel Jav 31. Date filed (Month, Day, Year AUG 0	10 (v); 4 (rar's Signatu	ראל לי א	Rilvili	e Rd	A312	BONI	e M	20716
	Registr	ar	AUG 0	8 2007 Kee	we h	4 A	meli					

Redient Known and Balderez-Werdoza, Baltimore, Maryland 21215-0036 Argel

	/N	ledical aminer
	EX	annier
on or vital Records, P.O. Box 68/60,	ding Physician; The law requires that the death certificate be executed	After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit

	For State Registrar	Ce	rtificate of De		Reg. No.	
n	1. Decedent's Name (First, Middle, Last) Angel Mendoza Balderas			2. Date Mont		3. Time of D
al				Hya	st 3 2	2007 105 hty of Death
er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Local Parties		4c. Cour	ny or beam
	5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Acres 1	Inder 24 Hrs. 8. Date	of Birth	9. Birthplace (State or F
	220-77-4032 XX ^{M 2□F}	Yrs.	Months Days Ho		th, Day, Year) il 4, 200'	Country)
	Usual Residence of Decedent			***************************************	11 1/ 200	
_	10a. State 10b. County Maryland Anne Arundel	10c. City, Town or Lo	acation Annapo	olie		10d. Inside City
Director	-				10.00	
	10e. Street and Number 609 Wye Island Court		10f. Zip Code	403	10g. Citizen o	of What Country?
erai		Ever in IIS 13			or No- 14, R	lace - American Indian,
Funeral	11. Marital Status 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ Married		Was Decedent of Hispar If Yes, specify Cuban, M		c.) B	lack, White, etc.
þ	3 ☐ Widowed 4 ☐ Divorced		1XX Yes 2□ No Sp	ecify: Mexical	n Spec	cify: White
ted	15. Decedent's Education		dent's Usual Occupation		16b. Kind of	Business/Industry
ble	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	life.	DO NOT use retired)	y most of working		/-
Completed	N/A		N/A			N/A
Be	17. Father's Name (First, Middle, Last) Martin Mendoza—Aquilar			Mother's Name <i>(First, N</i> adalupe Ba		
0						
	19a. Informant's Name/Relationship (Type. Print) Martin Mendoza—Aguilar/fat		ng Address (Street and I Tye Island (Number, City or Tow colis, Ma:	
		20b. Place of Disp		Date Date		n - City or Town, State
	20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State	cemetery, cre	matory or other place)			
	4 □ Donation 5 □ Other (Specify)		Crematory	8/6/2007		ore, Maryland
	21. Signature of Funeral Service Licensee					Funeral Home polis, MD 214
	23a. Part1. Enter the disease, or complications that caused					Approximate
J Y	shock, or heart failure. List only one cause on each lin	e.	<			Interval Betwee
	disease or condition resulting in death)	a constance of):	repos			30 h
Je.		a consequence of):				
Examiner	cause, Enter Underlying Cause (Disease or injury that initiated events c					
	resulting in death) Last Due to (or as a	a consequence of):				
Physician/Medical	d					
Mec	IF FEMALE:					<u>_</u>
ian/		2 Fetal death 3	□Ectopic pregnancy		I .	Date of delivery Month Day Ye
ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 9 ☐ Unknown	urne or death 5	Other (specify)			
	Part II. Other significant conditions contributing to death but	ut not resulting in the	underlying cause given in	Part I. 23e	. Did tobacco use c	ontribute to the cause of dea
d b		ralies	, ,		1 ☐ Yes 2 ☐ No	3 Probably 4 □Un
- 4	chalestatic javrance.		and broad	ato see - las	. Was an 24	Ih Wara gutanou findings
ete	CHARACTER JOSOFORCE	partial	pourty pagit	MIKINDIN 24a	autopsy performed?	lb. Were autopsy findings av prior to completion of cau death?
mplete	hydronephrosis			100	Yes 2□No	1 Yes 2 14No
	25. Was case referred to medical examiner? 1 Types 20 No. Hospital: 1 Proposition	nt 2 🗆 🗆 🗆	Other	Place of Death (Check		Othor (Cur-16)
g	27. Manner of Death 28a. Date of Inju	ry 28b. Time	III SLIDOA	Nursing Home 5 28d. Des	☐ Residence 6 ☐ 6 ☐ 6 ☐ 6 ☐ 6 ☐ 6 ☐ 6 ☐ 6 ☐ 6 ☐ 6	
To Be	1 Natural 5 □ Pending (Month, Day	Year) Injury	Work?	2 🗆 No	. ,	
To Be	TEMATOR OF THE PROPERTY OF THE		l treet, factory, office			ımber or Rural Route Numbe
lo Be	2 Accident investigation 3 Suicide 6 Could not be	ury - At home, farm, s		City	or Town, State)	
lo Be	2 Accident investigation					
Certification: To Be	2 Accident 3 Suicide 4 Homicide 28e. Place of injudent building, etc.	c. (Specify) of my knowledge, dea				
Certification: To Be	2	o. (Specify) of my knowledge, dea f examination and/or i				
Certification: 10 Be	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 1 Accident 3 Suicide 4 Medical Examiner: On the basis of	o. (Specify) of my knowledge, dea f examination and/or i		on, death occurred at the	e time, date and place	
Certification: To Be	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the basis of and manner sta	o. (Specify) of my knowledge, deaf f examination and/or intention	nvestigation, in my opinio	on, death occurred at the	e time, date and place	ce, and due to the cause(s)
Certification: To Be	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certife)	o. (Specify) of my knowledge, dea f examination and/or i ated.	29c. License nu	on, death occurred at the	e time, date and place	ce, and due to the cause(s)
Medical Certification: To Be Completed	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of per 1 who completed as seed of december 1 Certifying Physician: To the basis of and manner state 30. Name and address of per 1 who completed as seed of december 1 Certifying Physician: To the basis of and manner state 30. Name and address of per 1 Who completed as seed of december 1 Certifier Certifier 30. Name and address of per 1 Who completed as seed december 1 Certifier 30. Name and address of per 1 Who completed as seed december 1 Certifier 30. Name 2 Certifier Certifier 30. Name and address of per 1 Who completed as seed december 2 Certifier 30. Name 2 Certifier Certifier 30. Name 2 Certifier Certifier 30. Name 2 Certifier Certifier 30. Name 2 Certifier Certifier 30. Name 2 C	o. (Specify) of my knowledge, dea f examination and/or i ated.	29c. License nu	on, death occurred at the	e time, date and place	ce, and due to the cause(s)

			For State of Ma	ryland /		rtment of H tificate of L		-	giene Reg. No		
	Dhysisi		Decedent's Name (First, Middle, Last)					2. Date of De			3. Time of Death
	Physicia /Medic		Kathryn Anna Broseker					AUGUSI	06	2007	8:35 A ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) Berlin Nursing & Rehabilita	tion C	tr.	Berlin	Location of Death		40	County of Death Worceste	
-	Funeral Director			(In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Feb. 1	h y, Year)	9. Birth Cor MI	nplace (State or Foreign untry)
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	ation					10d. Inside City Limits
	ith with the Marylan 23a or 28a-f show ust be notified at	tor	MD Worcester	0cea	n Pir	ies					1 ☐ Yes 2 📉 No
	th the or 28a e noti)irec	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Cou	untry?
	ath wi	eral [#1 Golden Eye Court	in a la la la la la la la la la la la la l	40.16	218		if: V N-		ISA 14. Race - Amer	don Indian
HRYN 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. The Maryland marked other than "natural" or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 27 N If Yes, Give Year or Dates:			Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	-	Black, White	e, etc.
	72 hc	eted	15. Decedent's Education (Specify only highest grade completed)	16	6a. Deced	ent's Usual Occupa	ation during most of work)	ing	16b. K	ind of Business/I	ndustry
RY.	within ene. than '	Completed	Elementary/Secondary (0-12) College (1-4or 5-		Homen)		n	wn Home	
HLI	buld be filed with Mental Hygiene arked other than atic event, the Inc.	Be Co	17. Father's Name (First, Middle, Last)		TTOME	Idikei	18. Mother's Nam		Maider	Surname)	
KA Var	Mental Mental arked c	To E	William Scheclels				Gladys :	Stolten	berg		
KER, KAT	nd 2 salth ar		19a, Informant's Name/Relationship (Type. Print) Roland Broseker		P.O.	Box 3600	, Ocean	City, M	d. 2	1843	
BROSECKER, KATHRYN Ralimore Marvland 21215	Page nent c		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ceme	Henla	ition (Name of atory or other place pen Crem	Aug.		Fran	kford, l	DE
BR	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee				m St., B		_		Home
اء	Physician /Medical		resulting in death)	clus	tic	r the mode of dyin	g, such as cardiac	or respiratory a	rrest,	2	Approximate interval Between Onset and Death
	Examiner		Due to (or as a	a consequent	ce of):						
	SELECT SE	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence	ce of):						,,
	ecuter and -trans	Examine	Cause (Disease or injury that initiated events c curesulting in death) Last Due to (or as a	oonsaguan	on of):						
8760	cate be executed physician and the bunal-transit	dical E	d d	Consequen	oc 01).						
Œ	tificate ng phy as the	Nedic	15 55 AV 5								
C B C	. T 0 0	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	ath 3 🗌	Ectopic pregnancy Other (specify)	,			23d. Date of deli Month	very Day Year
٥	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to death but	it not resulting	g in the un	derlying cause give	en in Part I.				the cause of death?
7	requir	eted			-			1 🗆		!□No 3□Pr	
Division or Vital Becords D O	sician: The law certificate has t irector, page 2 s	Completed							psy ormeo! 2 N	prior to c	topsy findings available completion of cause of 2 ☐ No
5	Physiclan: ir this certifica aral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 1 No Hospital: 1 Inpatie	nt 2 □ ER/	Outpatient	3□ DOA Oth	er: 4 Nursing Ho			6 □Other (Spec	cify)
Č	ng Ph ter thi	n: T	27. Manner of Death 1 Natural 5 Pending (Month, Day		b. Time of Injury	28c. Injur Worl		28d. Describe			
	tendir eath. tor: Af the fu	catio	2 Accident investigation			M 1 🗆	Yes 2 □ No				
	l or At after d Direct	Certification:	4 ☐ Homicide determined 28e. Place of inju	ry - At nome :. (Specify)	, tarm, stre	et, factory, office		City or To			ıral Route Number,
	To the Hospital or Attending R within 24 hours after death To the Funeral Director; After completely filled in by the funer.	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the tir	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s	s) and manner as ad place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	. 7		29c. Licens	e number 28から	9	29d. Da	ate signed (MorN)	h, Day, Year)
	BAT	- 8	30. Name and address of person who completed cause of do	120	(Type, F	example !	He leve !	Ferre	to	Island, A	De 19944
	Sta Registr		31. Date filed (Month, Day, Year) 32. pegistra AUG 0 7 2007	er's Signature	4	ods)	9 /				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2, 2007 Marcia Ann Barnhart 11:05 P M August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5568 N. Annapolis Dr. Frederick Mount Airy If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F 186-38-6444 49 Oct 3, 1957 Director Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2XXNo Director Frederick MD Mount Airy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21771 5568 N. Annapolis Dr. United States Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2**X** No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CleveAly, LLC President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Lee Fike Clarence Veach Martin မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Barnhart Husband 5568 North Annapolis Dr. Mt. Airy, MD 21771 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State South Carroll Crematory Aug. 6, 2007 Winfield, MD 21784 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Fuenral Home & Crematory,
1212 W. Old Liberty Road Winfield, MD 21. Signature of Funeral Service Licenses -druns Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death rumediate Cause (Final di ease or condition Head & neck cancer **Physician** 18 months /Medical Ming in (leath) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 2 Fetal death Day Year 4⊡Pregnant at time of death 5 Other (specify) detached 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ▼ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2XXIo autopsy performed? 1□ Yes 2€No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home XX Residence 6 Other (Specify) 1 ☐ Yes 🏋 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deal 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

Division or Vital Records, P.O. Box 68760.

within 24 hor To the Fune WIL 10

Medical

State Registrar (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leon C. Hwang, M.D. Medical Oncology 1396 Piccard Drive Rockville, MD

31. Date filed (Month, Day, Year) 32. Registrar's Signature

2007

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D45880

29d. Date signed (Month, Day, Year)

August 3, 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Aug. ^Y2007 0120AM **Physician** Michael A.Bloom /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Westminster Examiner Dove House Carroll If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day Year Jan 30,1958 5. Social Security Number 215-50-4877 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral Months PA PA 12M 2□F 49 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show ITELT: ust be notified at Carroll Taneytown 1 Yes 2 No MD Director 10e. Street and Number 10g. Citizen of What Country? 3330 Black Schoolhouse Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White ō t ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) is markad other than Paved Roads Road Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Erb Fred Bloom ပ 19b. Mailing Address (*Street and Number or Rural Route Nu*mber, City or Town, State, Zip Code) 3330 Blacks Schoolhouse Rd, Taney town, MD21787 19a. Informant's Name/Relationship (Type, Print) Anita Bloom -Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ØCremation 3 ☐ Removal from State Hampstead, MD21074 8/9/07 ⁴ □ Donation 5 □ Other (Specify) Carroll Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruhard ditt Little's FH 34 Maple Ave.Littlestown, FA 23a. Part1. Enter the dise se, or complications that or used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) metastatic colon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4⊡Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed2 1 ☐ Yes 2 No To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Pother (Specify) HoSpice 1 Yes 2 No ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) ieral Diractor: After the filled in by the funeral 28d. Describe how injury occurred 27. Mannes of Death 28b. Time of Certification: 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD032337E (PA) WIL 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lover LANE HANOVERTA 460 MD Barbara 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 8 2007 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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	1		For State Registrar		State	of Ma	arylan		artment of rtificate of			ental Hy	/gien Reg. N	00.	-	25812
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21215-0036	n 72 hours after death w "natural", or items 23a sdical Examiner must b	Completed	(Spec	15. Decedent's	Education	ed)		16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retir	pation during n	nost of worki	ng	16b.	Kind of Busin	ess/Ind	iustry
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<u>S</u>	al or after al Direction	Certification:	4 Homicide		_ b	ullaing, e	tc. (Specif	y)				City or T	own, Sta	ire)		
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		For State Registrar		State o	f Marylar		artment o			ental Hy	giene Reg. No.	77	00013	
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Examin		4a. Facility Name (If not institution, gi	ve street and nu	mber)		4b. City, Tow	n, or Location	of Death		4c. County	of Death		
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Funeral Director		150-44-		1☐M 2 ⊠ F	7. Age (In yrs. 56	Yrs.		ays Hours	Min.	Month, Da 12/08	3/1950	Cour	lace (State or Foreign stry) Jersey	
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Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S										State, Zip		
		James I	Podlas/I	3rother			34 Ke		ad (Chance	, Mary			
if iten or oth		20a. Method of Dis 1 Burial 2	position ☐Cremation 3 [Removal from		Place of Dispo cemetery, cren	sition (Name on matory or other	f place)	D	ate	20c. Location -	City or To	own, State	
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0/0		30. Name and add	ress of person who	completed cau	of death (Iten			- 4 A7	0		10000	10	1000	
(a)		30. Name and address person who completed cause of death (Item 23a) (Type, Print) SVETLAMM GUTIERREZ 1415 SONTH DIVISION SMITE B. SACISBARS MO 21804												
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Registr	ar		AUG 0 7 2	UU/	202000	A. So	view							

			1 - For State Registrar		State of M	aryland / De <i>C</i>	partmer <i>ertificat</i>			Mental Hy	/giene Reg. Na	6001	25047
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	or 2	- E	10e. Street and Nun	nber			10f. Zip	Code			10g. Ci	itizen of What Co	ountry?
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	ems	Ine	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	Was Dece If Yes, spe	dent of H	ispanic Origin? (an, Mexican, Pue	(Specify Yes or Norto Rican, etc.)	0-	14. Race - Ame Black, Whit	
36	or it	Y.	21	ed 2 Married	1 ☐ Yes 2 🔯 If Yes, Give	No	1 ☐ Yes	2 🔯 No	Specify:			Specify: W	
21215-0036	be filed within 72 hours after deeth with the Maryland tal Hygiene. Individual than "natural" or items 23a or 28e-f ehow event, the Medical Expri per must be notified at	d by	3 🗆 Widowed		Year or Dates:	-							
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Baj	permit. Pages Department of H Importent: If its any injury or of		21. Signature of Eur	negal Service Lice	need Ble	Se				Bounds Fu			and 21804
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Box	death certifi e attending ed for use as	Physician/M	23b. Was decedent		23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Fetal death	3 □Ectopic pr	regnancy				23d. Date of de	,
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ital	ian: Th rtificete ctor, pag	Bec	25. Was case refern	ed to medical					26. Place of De	eath Check only	-/-	, , , , ,	
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	rs aft el Di ed in	Certification:			22.33.79, 60	(, otali	-/	
•	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier (Check only	1 Certifying P	hysician: To the best miner: On the basis of	of my knowledge, d	eath occurred	at the tim	ne, date and place	ce, and due to the	cause(s	and manner as	s stated.
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	with To Con	Σ	29b. Signature and t	title of certifier	/ P		290	. License	number C		29d. Da	ite signed (Mont	h. Day, Year)
,	.1 0		<u> </u>		I M.			16	420	-7	>	57210	ナ
	4 m		30 name and addre	ess of pers	pleted cause of d	eath (Item 3a) (Ty	e Print)	0	1 7	1/	200	710	11
			MHAM	1- Perce	943	18911	way	1/16	K 12	Min /	M()	2181	(
	Sta		31. Date filed (Monti	H. Day Year)	2007 32. Registra	ar's Signature	# 1		1/-			-	
	Registr	ar			POR	4821 LA	Salar Car	j					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 08 GEORGE CROUCH 07 0530 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Aug 22, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months **X**□ M 2 □ F 134-05-9478 91 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show "natural", or items 23a or 28a-f shov dical Examiner must be notified at Cumberland MD Allegany X□Yes 2□No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15420 Shamrock Road, SW 21502 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

Î ☐ Yes 2 ☐ No
If Yes, Give Year or Dates; WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married Ž☐ Married 1 ☐ Yes 2 📉 No altimore, Maryland 21215-0036 Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Swift and Company superintendent Department of Health and Mental Hygis Important: If Item 27 Is marked other any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kate Dennison Crouch Dwight B. Crouch 2 o. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)* 15420 Shamrock Rd., Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) Elizabeth Crouch wife 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Immaculate Conception Cem 1 Burial 2 □ Cremation 3 □ Removal from State 8/27/2007 PΑ Clarion 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service License, 22. Name Scandenis Puliferial Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lim. Imme of te Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a convequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of 24a. Was an performed death?
1 ☐ Yes 2 No 2 ☑ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manne Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

Registrar

30. Name and address of person who completed

AUG 2 1 2007

31. Date filed (Month, Day, Year

cause of death (Item 23a) (Type, Print)

Registrar's Signature

92

			For State	State of Ma	aryland /		rtment of <i>tificate o</i>	Health and	Mental Hy		1000	
	-		Registrar 1. Decedent's Name (First, Middle, Las	et)		061	incate o	Death	2. Date of De	Reg. No.		3. Time of Death
	Physicia /Medic		1. Decedent's Name (1 its), whome, Las	Verna E	rnesti	ne	Challe	enger	Month AUGL	Day	Year 4, 200	
	Examin	-4	4a. Facility Name (If not institution, give Saint Joseph			ارا	4b. City, Towr	, or Location of Dea		4c. C	ounty of Deat	timore
- 2-4	Funeral		5. Social Security Number 6. S		ge (In yrs. last b	oirthday)	If Under 1 Ye		s. 8. Date of Bi	rth	9. Birt	thplace (State or Foreign ountry)
	Director		122-40-8969	□M 2 X □F	62	Yrs.	Months Day	s Hours Min	July		945	Anguilla
			Usual Residence of Decedent									
	how how		10a. State 10b. County		10c. City, To	wn or Loc	cation					10d. Inside City Limits
	e Ma ia-f s tifled	cto	Maryland				Balt	imore				1 ☐ Yes 2√ No
	or 28	Director	10e. Street and Number				10f. Zip Cod				en of What Co	ountry?
	ath w	<u>ra</u>	1318 Glenmont	Road			<u> </u>	21239		U.S		
	tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	?	13. V	Vas Decedent of FYes, specify C	of Hispanic Origin? Suban, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	0- 1	 Race - Ame Black, Whit 	
36	be filed within 72 hours after death with the Maryland Hygliene. id other than "natural", or Items 23a or 28a-f show dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	1	□Yes 2X	lo Specify:			Specify: Bl	ack
21215-0036	hour tural	8	15. Decedent's Ed		16	l Sa. Deced	lent's Usual Oc	cupation			d of Business	
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Ö	filed Hygid Sther ent, tl	Be C	17. Father's Name (First, Middle, Last)	5+				18. Mother's N	ame (First, Middle	e, Maiden S	Surname)	
Maryland	should be nd Mental marked o	To B	Ţ	Walter H	odge			Edna	Challe	enge		
ary	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (Type. Print)	19	9b. Mailin	g Address (Str	eet and Number or	Rural Route Num	ber, City or	Town, State,	Zip Code)
	s 1 and 2 should if Health and Mer Item 27 Is marke other traumatic		Luther Dolcar	/ Son-in	-Law 1	318	Glenn	ont Roa	d_Balti	more	.Marv	land 21239
altimore,		. 3	20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □		l ceme	of Dispos tery, cren	sition (Name of natory or other	place)	Date	20c. Loc	ation - City or	Town, State
Ĕ	Pages nent of I ant: If Ita ury or o		4 □ Donation 5 □ Other (Specif			hil	l Ceme	terv 8/	23/07	st.	Croix	,U.S.,VI
	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service Licer	nsee	1	0.0	Alexand and Ad	done - of Partition				*
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П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plication that cause one cause on each I	d the death. Dine.	o not ent	er the mode of	dying, such as card	iac or respiratory	arrest,		Approximate Interval Between Onset and Death
No.	Physician		Immediate Cause (Final disease or condition	RESPI	RATORY	FA	ILURE					Onset and Death
E.	/Medical		resulting in death)		a consequenc							
	Examiner	_	Sequentially list conditions,	b	TATIC		DN CAN	CER			_	
	pe tis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consequenc	ce or):						
2	xecut and Il-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	s a consequenc	e of):						
8760,	cate be executed physician and the burial-transit	alE				,						
387		dical		d								
×	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						2	3d. Date of de	elivery
m	atter for u	ciar	in the past 12 months?		2 □ Fetal dea at time of death		∃Ectopic pregna ∃Other <i>(specif</i>)				Month	Day Year
o.	the o	ηλsi	9 Unknown	9□Unknown								
~ <u>`</u>	s that ned b	by P	Part II. Other significant conditions	contributing to death	but not resulting	g in the u	nderlying cause	given in Part I.	23e. Dio	tobacco us	se contribute t	to the cause of death?
ğ	w require been sig should b	p p	RENAL FAILURE						_ 1[Yes 2	No 3□P	Probably 4 Unknown
ပ္က	aw re is bee	Completed	SEPSIS						24a. Wa	s an opsy	24b. Were a	autopsy findings available completion of cause of
ž	The lav	E							pei 1□ Yes	formed2	death?	
Ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical					26. Place of I	Death (Check only	/ \		
>	hysician: his certifica i director, i	To E	examiner?* 1 ☐ Yes 2 No	Hospital: 1 Inpat	tient 2 ER/	Outpatier	nt 3□ DOA	Other: 4 Nursin	g Home 5 □ Re	sidence 6	3 □Other (Sp	ecify)
0	dlng Ph n. After thi funeral	nc.	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D		b. Time o Injury	f 28c.	njury at Work?	28d. Describ	e how injury	y occurred	
Division or Vital Records, P.O. Box	eath. or: A	Certification:	2 ☐ Accident investigatio					1 ☐ Yes 2 ☐ No				
Ξ̈́	or Att ter de irect	ŧ	3 ☐ Suicide 6 ☐ Could not be determined	20e. Place of II	njury - At home, etc. <i>(Specify)</i>	, farm, str	eet, factory, of	ice		(Street and own, State)		Rural Route Number,
Ω	urs af		00-0-00	business To 11	A of more long and		h anni	o timo data '	ana and door to the		and mark	an otated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical		hysician: To the bes miner: On the basis and manners	of examination							
	o the ithin (o the ymple	Mec	29b. Signature and title of certifier	and manner s		w	29c. Lie	ense number		29d. Dat	e signed (Mor	nth, Day, Year)
	F ≥ F ŏ		Rich	1 15	this:	T * **	_	1826		1	-14	
7			30. Name and address of person who	completed cause of	death (Item 22	a) (Tyne		r ate loof hoss les'				
	V			VTHICUM.				R_DRIVE	TOWSON	I. MO	RYLAN	D 21204
		ate	31. Date filed (Month Pay Year)	- F.O.	trar's Signature		A STATE OF THE STA	The state of the s	y nor v v loof loof E		moos 8 8 %	

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Year Month **Physician** A M 16, William Frederick Cass Aug. 4:10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours Min. 11X M 2□ F 93 1914 Ohio 278-36-2764 Director May 5, Usual Residence of Decedent nd 2 should be filed within 72 hours after death with the Maryland filth and Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1XYes 2 No Director Maryland | Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 5101 River Road #1902 20816 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1937 — If Yes, Give Year or Dates: 1967 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) US Coast Guard Captain 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Arthur Cass Minnie Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 6670 Hillandale Rd. Chevy Chase, MD 20815 Judith C. Armbrister /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National 20a. Method of Disposition 20c. Location - City or Town, State Pages 7 Department of Important: if it any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Nov. 1,2007 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur al Service Lio 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, D.C. 20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner b. Atheroscelrotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be Sepsis, Pneumonia, Advanced Dementia, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Cerebrovascular Accident, atrial fibrillation page 2 autopsy The perform certificate 1∐ Yes 2**X** No Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After Hospital or Attending 5 ☐ Pending investigation (Month, Day Year) 1 X Natural or A.

As after deau.

Al Director: A

in by # 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D53367 Aug. 16, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Rajan Shyamsundar, M.D. 98011 Georgia Ave. Silver Spring, MD 20910

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registra



Baltimore, Maryland 21215-0036

Records,

Vital

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Division

		For State Registrar	State of M	aryland		rtment of F tificate of		Mental Hy	/giene Reg. No.	000	25740
Physicia	nn.	Decedent's Name (First, Middle, Last)					2. Date of D		Year	3. Time of Death 430 AM
/Medic	al	Etheline 4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of Dea	Augus		ounty of Dea	
Examin	er	Doctors Communi		_		Lanh		0			Georges
Funeral Director		5. Social Security Number 6. Se		ge (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ay, Year)		nthplace (State or Foreign ountry)
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Maryla f shoried at	tor	D.C		Wa	shind	gton, D	. c.				Yes 2□No
h the or 28a	irec	10e. Street and Number				10f. Zip Code			10g. Citize	en of What C	ountry?
ath wit 23a c ust be	ral	2126 - 13th St					020			USA	avison Indian
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give	?		Vas Decedent of H Yes, specify Cub ☐ Yes 2☐ No	fispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)		Black, Wh	erican Indian, ite, etc. Black
72 hours "natural" edical Exa	Completed by	3 Widowed 4 □ Divorced 15. Decedent's Edi (Specify only highest grad			(Give I	ent's Usual Occup kind of work done O NOT use retire	during most of wo	orking	16b. Kin	d of Business	s/Industry
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d2sh thand 7ism traum		19a. Informant's Name/Relationship (7) Winifred Dowd (~ \		Address (Street - 13t				Town, State,	Zip Code)
ges 1 an It of Heal If item 2 or other		20a. Method of Disposition 1 Disposition 2 Cremation 3		20b. Pl	ace of Dispos	nington sition (Name of natory or other pla	ce)	Date	20c. Loc	,	r Town, State
it. Pa trtmen rtant: njury		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen		Mt.		vet Cem		-09-07			on, D.C.
permi Depar Impor any Ir	9 9	1/ (alph &	. Will		11		omac Ay	<i>r</i> e.,S.E	.; W	rvice ash.,	DC 20003
Physician	e v	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each l	line.					arrest,		Approximate Interval Between Onset and Death LNK NOUN
/Medical Examiner		resulting in death)	Due to (or as	s a consequ	ence of):	vtery orillat	10n				unknown
be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as		ionao of):	pagat					
cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	s a consequ		Juput,	7				
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ath certific aftending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a	2 Fetal	death 3	Ectopic pregnanc	y		2	3d. Date of d	elivery Day Year
the de	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	at time or de	Juli 0_	jetner (speary) _					
ysician: The law requires that the death certif is certificate has been signed by the aftending director, page 2 should be detached for use as	by	Part II. Other significant conditions of	ntributing to death			derlying cause gi	ven in Part I.		,		to the cause of death? Probably 4 Mulnknown
he law rec has bee ge 2 shou	Completed	,	J'					24a. Wa aut per	s an opsy formed? 2 1 No	prior to death?	autopsy findings available o completion of cause of
an: Tificate		25. Was case referred to medical					26. Place of De	1 Yes eath (Check only		1 □ Y€	es 2 No
nysich	To Be	examiner? 1 ☐ Yes 2 1 No	Hospital: 1 X Inpat	ient 2 🗆 I	ER/Outpatien	t 3□ DOA Ot	her: 4 🗆 Nursing	Home 5□Re	sidence 6	□Other (Sp	pecify)
ing Pt		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D	jury lay Year)	28b. Time of Injury	28c. Inju		28d. Describe	e how injury	occurred	
or Attend fter death. Virector: / n by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of II	njury - At ho etc. <i>(Specif</i> y	me, farm, str	M 1 □]Yes 2□No		(Street and own, State)		Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the aftending opminately filled in by the funeral director, page 2 should be detached for use as	Medical Ce		/sician: To the bes iner: On the basis and manners	of examinat							
Fo the within 2	Med	29b. Signature and title of cerufier	and manners	nateu.		29c. Licen	se number		29d. Date	e signed (Mo	nth, Day, Year)
(4)		▶ Yau	en mg				61661		81	3/07	
P		30. Name and address of person who		death (Item	23a) (Type,	Print) 7	Groon	over f	arkn	My Si	icte 101 A
Sta	ate	31. Date filed (Month, Day, Year) 20		trar's Signa			-11-(1/1)	11	112 7	UITU	

Division or Vital Records, P.O. Box 68760,

			1- State of Maryland / Dep State of Maryland / Dep Registrar Ce	artment of Health and N rtificate of Death	Reg. N	1111 19	28860
ŧ	Physicia		1. Decedent's Name (First, Middle, Last) Stephen Clark		2. Date of Death Month 08/03	7 ² 2007 ^{Year}	3. Time of Death 7:00 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Cheverly	4	c. County of Death	roe's
	Funeral Director		Prince George's Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 20 F 69 Yrs.		8. Date of Birth		place (State or Foreign of try) geburg, SC
	ט		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		1	0d. Inside City Limits
	e Mary ta-f sho tified a	ctor	MD Prince George's Capitol	Heights			1 ☐Yes 2 ☐ No
	with th 3a or 28 st be no	I Dire	10e. Street and Number 11 Pepper Mill Dr	10f. Zip Code 20743	10g. (Citizen of What Cour	usa
200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hylgine. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No 1961 — If Yes, Give Year or Dates: 1963	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ★ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: B1a	etc.
N-C17	<i>i</i> ithin 72 hou ne. han "natur i e M dical E	Completed	(Specify only highest grade completed) (Giv. Stementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) ck Driver	ing	Kind of Business/In	
allu z	1 and 2 should be filed with Health and Mental Hygiene. em 27 is marked other thar wither traumatic event, the M	Be	17. Father's Name (<i>First, Middle, Last</i>) XO Clark	18. Mother's Name	e (First, Middle, Maide Williams		
Maly	and 2 should be ealth and Mental n 27 is marked o ner traumatic eve	To	19a. Informant's Name/Relationship (Type. Print) Marilynn Clark/ daughter 19b. Mai	ing Address (Street and Number or Run epper Mill Dr., Ca	al Route Number, City apitol Hei	y or Town, State, Zipghts, MD	20743
ָה בֿ	Pages 1 al nent of Hea nt: If Item		1 🔀 Burial 2 🖂 Cremation 3 🖂 Hemoval from State	osition (Name of ematory or other place) oln Cemetery 8/10		Location - City or To	
	permit. F Departme Importar any Injur once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility For 401 Bladensburg Ro	t Lincoln	Funeral	Home
ı			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a	flood	-7	١.	
	Examiner	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, [Disease or injury]	Loton Le	eren	gma	
,00,00	be execut sician and burial-tran	al Examiner	that initiated events c. Due to (or as a consequence of):				
	rtificate ng phys as the	Aedical	d.				
O. DOX	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year
cords, r.	quires that t in signed by uld be detad	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to t	
ם שבי	The law re ate has bee page 2 sho	Completed			24a. Was an autopsy performed 1 Yes 2 1	prior to co	opsy findings available mpletion of cause of
<u> [a</u>	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 A Inpatient 2 ER/Outpatie	Othor	th (Check only one)	0 Flother (6-1-1	£.3
5 5	To the Hospital or Attending Physician: The law within 24 butus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	tion: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) Injury 2 Induction investigation	of 28c. Injury at	ome 5 Residence 28d. Describe how in		<u>19)</u>
	al or Atter s after dea tl Director ed in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St		al Route Number,
	e Hospit 24 hours e Funers letely fille	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal (Check only one) Certifying Physician: To the best of my knowledge, deal (Check only one) Medical Examiner: On the basis of examination and/or and manner stated.				
	To th within To th	Me	29b. Signature and officeriffer	29c. License number		Date signed (Month	Day, Year)
	8		30 Name and address of person who completed cause of death (Item 23a) (Type DM: Janes Catevenis 3001 Hospe	Print) Dr. Cheverly	no 20	0785	/
	Sta Registr		31. Date filed (Month, Day, Year) ALIC 0 7 2007	,			

			For State Registrar	State of Mar		artment of F		, ,	iene eg. No.	26850
6			negistral Decedent's Name (First, Middle, Last)					2. Date of Deat	h	3. Time of Death
ы	Physici		Jay Samuel Dill	Lon				Month 8-	-3-07	,50 A M
2	/Medic		4a. Facility Name (If not institution, give si			4b. City, Town, o	r Location of Death		4c. County of Death	
.	LAGIIIII		Carroll Hospital Ce	enter		Westmins	ster		Carroll	
-	Funeral		5. Social Security Number 6. Sex	7. Age ((In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	9 Birth	place (State or Foreign
b	Director		219 – 03–6871	M 2□F	90 Yrs.	World Days	TIOUIS WIIII.	4/6/191		sylvania
	pu »		Usual Residence of Decedent 10a. State 10b. County	1	I Oc. City, Town or Lo	ocation				10d. Inside City Limits
	shov shov ad at	5	Maryland Carroll							1 ∐Yes 2 TXNo
	the N 28a-f lotifie	Director	10e. Street and Number		Manchest	10f. Zip Code		16	Og. Citizen of What Cou	intry?
	a or	ā	3424 Hanover Pike							,
	eath	Funeral		2. Was Decedent Ev	er in U.S. 13.	21102 Was Decedent of H	lispanic Origin? (Sp		Jnited Stat 14. Race - Amer	
10	fter d r Iten iner	ᇤ	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 XYes 2 ☐ No		If Yes, specify Cub	an, Mexican, Puerti	o Rićan, etc.)	Black, White	
98	urs a al", o Exarr	ا کو ا	3 ☐ Widowed 4 ☐ Divorced	lf ∜ ềs, Give Year or Dates:	WWII	1 ☐ Yes 2 🔀 No	Specify:		Specify: Wh	ite
ŏ	2 hor	ted	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occup	nation during most of work	kina	16b. Kind of Business/I	ndustry
2	thin 7 e. an "r	声	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	DO NOT use retired ting Egin	d)	Ning	II	h
2	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	7		Opera	cing Egin			Heavy Cons	truction
n D	be fill d oth even	Be	17. Father's Name (First, Middle, Last)				_	ne (First, Middle, M		
₹	ould Men narke	2	George Meade Dillo		1			Mae Sadl		
Maryland 21215-0036	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type June Theodore Dill	,	l				; City or Town, State, Z Maryland 2	
e,	1 and Healt sm 2 ther		20a. Method of Disposition	OII - WILE	20b. Place of Dispo		rike Halk		20c. Location - City or	~
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	П	1 🎇 Burial 2 □ Cremation 3 □ Re	ernoval from State	cemetery, cre	matory or other pla			•	
Ē	it. P.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	10	Forest R	idge Ceme 2. Name and Addre			Jpperco, Ma	ryland
Ba	perm Depa Impo any i		21. Signature of Vallagin Service georise				بند	line Fune	eral Home, vland 21074	934 South
	E AL		23a. Part1. Enter the disease, or complic	cations that caused th	ne death. Do not en					Approximate
	Dharainian		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line						Interval Between Onset and Death
2	Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequence of):		177			
	Examiner		A STANDARD OF THE STANDARD OF	1151	NAL I	NTERST	TITIAL	PNEU	monia	
h,		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):					
	cuted Id ansit	Examiner	that initiated events c.	_						_
o,	execan ar an ar rial-ti	Ĕ	resulting in death) Last	Due to (or as a	consequence of):					
8760,	cate be executed physician and the burial-transit	dical	d							
မ	ng pl	Med	IF FEMALE:		-					
Box	ath ce	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf 1 ☐Live birth 2	Fetal death 3	⊒Ectopic pregnanc	ey		23d. Date of deli Month	very Day Year
0	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me of death 5 [Other (specify)_				
<u> </u>	d by detacl	Ph	Part II. Other significant conditions con	stributing to death but	not resulting in the I	inderlying cause giv	ven in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ds,	The law requires that the death certific thas been signed by the attending page 2 should be detached for use as	by		-	J	, , , ,		1 □ Y€	es 2MNo 3∐Pro	obably 4 ∐Unknown
Ö	/ requ	Completed						24a. Was a	24h Wara au	to sou findings quallable
ě	ne law has ye 2 s	m du						autops	sv prior to d	topsy findings available completion of cause of
<u>_</u>	n: The		OF Management						med? death? 2X No 1 ☐ Yes	2 No
Division or Vital Records,	Attending Physician: r death. ector: After this certific. by the funeral director,) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	lospital:	t 2 ☐ ER/Outpatie	nt 3 DOA Oti	nor:	th (Check only on	ence 6 □Other (Spec	
o	Phy er this eral d	: To	27. Manner of Death	28a. Date of Injury	28b. Time of				ow injury occurred	лу)
O	th. th: Afte	ijo	Natural 5 Pending investigation	(Month, Day	Year) Injury		rk?]Yes 2∐No			
Visi	Atter	ijice	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, st	reet, factory, office		28f. Location (St City or Town	treet and Number or Ru	ral Route Number,
ā	al or s afte al Dir ed in	Certification:	4 El forniolac	bollang, etc.	(Openly)			l	i, Glato)	
	To the Hospital or Attending Physician: The law Within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		(Check only 2 Medical Examir	ner: On the basis of e	examination and/or in				au <i>s</i> e(s) and manner as late and place, and due	
	thin 2	Medical	29b. Signature and title of certifier	and manner state	ea	29c. Licen	se number	2	9d. Date signed (Monti	n, Day, Year)
	7 × 2 8	-	255. Oignature and title of certifier	and	2		0263		8-3-07	
7	WILVA		OO Name and additional	and the distance of the	ath (Itom 00-) (T		~ ~)		/	
	641		30. Name and address of person who co	mpleted cause of dea	ZCV ME	MORIAL	AVE, V	VESTMI	NSTER, M	021157
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signature					ľ
	Regist		AUC 0.7.2	DO7 Elma	. K	Sneet)				

			1 - For Stata Registrar	State of Marylan		artment o				iene.	1	25001
Ž	Physici		Decedent's Name (First, Middle, Last, Charles Duvall						2. Date of Dea Month August	Day 1	Year 2007	3. Time of Death
	/Medic Examir	7.0	4a. Facility Name (If not institution, give Prince George's				wn, or Local	tion of Death	Acadam	4c. Count	y of Death	George's
	Funeral Director		210-30-4430	7. Age (In yrs. 71	ast birthday) Yrs.	If Under 1 Y		nder 24 Hrs.	8. Date of Birth (Month, Day 04-24			lace (State or Foreign fy) yland
Maryland	e-f show	tor	Usual Residence of Decedent 10a. State 10b. County Prince (, Town or Lo						10	0d. Inside City Limits 1 AYes 2 □ No
with the	3a or 28 st be ro	al Dire	10e. Street and Number 9100 91st place	2		10f. Zip Co			1	0g. Citizen of USA		try?
ours after deat	arment of Health and Mental Hygiene. Artant: if item 27 is marked other than "natural", or items 23a or 28e-f show njury or other traumatic event, tra Mudical Exeminar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates:		Was Decedent f Yes, specify		c Origin? (Spe xican, Puerto ecify:	ecify Yes or No- Rican, etc.)	Bla	ce - America ick, White, e fy: Bla	etc.
1 within 72 ho	jiene. r than "netur Ine Mudical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual O kind of work o DO NOT use r Drive	lone during etired)	most of worki	ng	16b. Kind of E		ustry
y larite.	Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) Marshall Duval	.1				Della	(First, Middle, Tabbs			
and 2 sho	aith and 27 is m er traum		19a. Informant's Name/Relationship (Ty Mary Duvall	_{rpe, Print)} Wife					at Plea			
Pages 1 a	Department of Health a Important: If Itam 27 is any njury or other tra		20a. Method of Disposition 1		ametery crei	sition (Name of matory or other od Cem	r nlace)	I		20c. Location Washi		
permit.	Departr Imports any nju		21. Signature of Funeral Service License	99	1	Name and A	ddress of F	acility Sne akes I	ead Mor Pl Ste	tuary B Mit	Ser chel	vice,P.A lville,M
J	ysician Medical		23a. Part1. Enter the lisease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	opulm	pring	(01	lapse		est,		Approximate Interval Between Onset and Death
<i>M</i>	physicien and in the burial-transit in the burial-transit in the burial-transit in the transit i	dicai Examiner	Sequentially list conditions, if any leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of):	GRO	iony	spat(^7			Years
to the Hospitel or Attending Physician: The law requires that the death certificate be executed	ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of di 9 □ Unknown	death 3	Ectopic pregr Other (s <i>pecif</i>					ate of deliver	ry Day Year
uires that	n signed by the a lid be detached fo	þ	Part II. Other significant conditions cor	/	ulting in the u	, ,	e given in P	Part I.	23e. Did tol	~	itribute to the	e cause of death?
The law rec	ate has been s page 2 should	Completed	Sepso Sp.	ndune					24a. Was a autops perform	V	prior to con death?	osy findings available npletion of cause of
sician:	certific rector,	Be	25. Was case referred to medical examiner?	lospital: 🚅			Othac		Check only on			
P P	eratdi	다 :	27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time of		Injury at		me 5 Reside)
Attending	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ertification;	↑ Selection 5 Pending 2 Accident 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At ho	Injury me, farm, str	M eet, factory, of	Work? 1 ☐ Yes : fice			reet and Num	ber or Rural	Route Number,
spitel or	ours after neral Dire filled in b	OI	- Inomicide	building, etc. (Specify	′)			te and place a	City or Town		anner as sta	ated
o Ho	n 24 h he Fur oletely	edicai	(Check only 2 Medical Examinate)	ner: On the basis of examina and manner stated.	ion and/or in	estigation, in	my opinion,	death occurre	ed at the time, d	ate and place	and due to	the cause(s)
To th	I'	Me	29b. Signature and title of certifier	l faro			cense numl	ber 2865		9d. Date signed Augus		Day, Year)
	<i>\\D</i>		30. Name and address of person who co	aro, M.D. 30	23а) (Туре, 01 Но	Print)						
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa		1)						

DHWH 17 HeV 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 0609 2007 RUSSELL **EVANS** 6 WARREN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsyla NICOM 180 SAUSBUR REGIONA If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1X M 2□F 90 JULY 5, 222-09-6839 Director 1917 DELAWARE Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1X Yes 2 □ No Director DELAWARE SUSSEX SELBYVILLE 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be I 234 BAKER ROAD 19975 USA Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. e filed within 72 hours after al Hygiene. I other than "natural", or ite 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2K No Specify Completed by Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **FARMER** 12 AGRICULTURE permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARVEY Κ. ျ **EVANS** ELSIE DERRICKSON Μ. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVELYN A. EVANS/WIFE 234 BAKER ROAD, SELBYVILLE, DELAWARE 19975 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) REDMEN'S CEMETERY 8/10/07 SELBYVILLE, DELAWARE 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line o not enter the mode of dying, such as cardiac or respiratory arrest, Immedi lie Cause (Final **Physician** memoria disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of). attending physician for use as the huria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Trobably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy page certificate 1☐ Yes 2 No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours a completely

Division or Vital Records, P.O. Box 68760

222-09-6839

Baltimore,

State Registrar

2007

29b. Signature and title of certifie

(Check only one)

30. Name an address of

Chris

32 Registrar's Signature

rerson who completed cause of death (Item 23a) (Type, Print)

MO

100 & Carroll STRECT Solishum mo

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Mgnth, Day, Year)

3. Time of Death

2:30

аМ

Day

August 7, 2007

Year

Physician
/Medical
Examiner

Elia

John Esposito

Physician /Medical **Examiner** The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760, attending physician for use as the buria ed by the a detached f page 2 s Hospital or Attending Physician: funeral director, after death Director: filled in by 24 hours a Funeral I completely To the within 2

4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Laure1
er 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Prince George's Laurel Regional Hospital If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 № M 2 □ F 557-28-6217 Yrs. 20, 87 June Italy Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at New Hanover Wilmington 1X Yes ZINO Director Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 910 Reilly Dr. 28409-6930 20004 USA Funeral 14 Bace - American Indian Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1X Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 🕷 No Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Walter Reed Army and 2 should be filed within ealth and Mental Hygiene. n 27 is marked other than College (1-4or 5+) 5+ Elementary/Secondary (0-12) Researcher Medical Center 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vito N. Esposito Rosa Roselli ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any injury or other trau
once, Bruce A. Esposito/ Son 414 Williamsburg Drive, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State August 13. to Burial 2 ☐ Cremation 3 K Removal from State Gaston Memorial Park 4 □ Donation 5 □ Other (Specify) 2007 Gaston, North Carolina 21. Signature of Funeral Service Licensee Francis Collins Funeral Home Inc. Serves 5 020, 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. In ter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Lymphocytic Leukemia Months Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Anemia, Thrombocytopenia, Leukopenia, Pneumonia Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2**%** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Malnpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and till 29d. Date signed (Month, Day, Year) D24035 August 7, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3160 Gracefield Road, Silver Spring, MD 20904 Eugenio Machado, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 0 8 2001

Registrar DHMH 17 Rev 1/2001

State

VISHNU DEEPIKA EVURI

2. Registrar's Signature

THE JOHNS HOPKINS HOSPITAL, GOO NORTH WOLFE STREET, BALTIMORE, MD-21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Otate of Iviary	•	rtificate of l		Re	g. No.	
	Physic /Medi		Decedent's Name (First, Middle, La Rita Fa:	st) Lson				2. Date of Death Month Augus +	Day Year 2 200	3. Time of Death 7/0 p ^M
	Exami		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	119742.	4c. County of Deat	
10	e		Doctor's Community I			Lanhar			Prince Geor	
i-ia:	Funeral Director		5. Social Security Number 6. S 579–68–5785 Usual Residence of Decedent	Gex 7. Age (In ☐ M 2 [X]F	yrs. last birthday, 54 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, November		hplace (State or Foreigr untry) nington, D.C.
5	ow at		10a. State 10b. County	100	. City, Town or L	ocation		· ·		10d. Inside City Limits
Mo	Ba-f sh	ector	Maryland Prince Geo	orge's		Bowie	5	140	0:2:	1 \ es 2 \ No
4	23a or 2 ust be n	Funeral Director	10e. Street and Number 10402 Bald Hill Ro	oad		10f. Zip Code	20721		g. Citizen of What Co U.S.A.	
036	within 72 hours after death with the Maryland ene. than "natural" or items 23a or 28a-f show he Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2【XXII arried 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 XX o If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes Yes	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B	
2-0-2	"natul	etec	15. Decedent's E (Specify only highest gro	ducation ade completed)	16a. Dece	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of work	ing 1	6b. Kind of Business/	Industry
212	giene.	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)	Lau	ndry Engine	er]	Heartland Nu	rsing Center
an	or Smooth be lined within 7.2 Hz th and Mental Hygiene. 7.1s marked other than "natul traumatic event, the Medical	To Be C	17. Father's Name (<i>First, Middle, Last</i> John A. So.	therland			18. Mother's Name	e (First, Middle, M Daisy Sm		
	alth and Ma 27 Is marl er traumati		19a. Informant's Name/Relationship (Mr. Raifel Faison (H	** /	I .	ing Address (Street Bald Hill I			City or Town, State, 2	Zip Code)
Baltimore,	iges I and of Healt I if item 2		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	Ob. Place of Disp cemetery, cre	osition (Name of ematory or other place			20c. Location - City or	Town, State
֟֞֟֝֟֝֟֝֟֝֟֝֟֝ <u>֟</u>	~ ` = >		4 Donation 5 ☐ Other (Speci	(y) N		et Cemetery			Washington, I al Home, Inc.	
Bal	Departme Importan any injur once.		21. Signature of Funeral Service Lice	Jan.					, D.C. 20019	
-	hysician /Medical Examiner		23a. Art1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Meta Due to (or as a cor	stati	nter the mode of dyin	_			Approximate Interval Between Onset and Death
68760, F	g physician and as the burial-transit	al Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c			_			
687	uncate ig phys as the	ledical		d						
Box	e attendin	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>	,		23d. Date of del Month	ivery Day Year
₽ ∄	een signed by the a nould be detached to	by	Part II. Other significant conditions	contributing to death but no	t resulting in the (underlying cause giv	en in Part I.		acco use contribute to	o the cause of death?
Rec	has b ye 2 sl	Completed						24a. Was ar autops perform 1∐ Yes 2	prior to death?	utopsy findings available completion of cause of 2 XNo
Zi za	certificate rector, pag	Be	25. Was case referred to medical examiner?					th (Check only one	-5	
or Vital	g .g.	မ	1 ☐ Yes 2 No	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatie		4 Li Nursing H		nce 6 Other (Spe	cify)
IVISION	After After funer	Certification:	27. Manner of Death 1 Aural 2 Accident 3 Suicide 4 Homicide 5 Pending investigatio 6 Could not be determined	(Month, Day Ye	At home, farm, s	M 1 □	yal k? Yes 2 □ No	28f. Location (Str City or Town	eet and Number or Ri	ural Route Number,
_ ::000	within 24 hours after dear To the Funeral Director: completely filled in by the	Medical Ce		nysician: To the best of my miner: On the basis of exa and manner stated.						
To the	within 2.	Me	29b. Signature and title of certifier			29c. Licens	e number	25	d. Date signed (Mont	h, Day, Year)
	-, 0		Mans	0208		NDD.	537/8		8/3/07	2
	5	7	30. Name and address of person who		(Item 23a) (Type	, Print)	53718 ROAD L	AN HAN	ND 2070	160
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's		O LOCK	الله الله الله	in in it	J - / W	2
	Regist		AUG 0 7 2007	Ac 1.	South					

FAISON RITA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 98/1 9-20-07 vt.
State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		yland		tificate of				eg. No.	197	25.75	
F			1. Decedent's Name (First, Middle, La	st)						Date of Deat	h	V	3. Time of Death	
₹.	Physici /Medic		Everett I. Fogle, Jr.				Month 8/			'05/20	Year 07	13:45 M		
	Examin		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. Cour	4c. County of Death			
	*		Anne Arundel Medical Center				Annapolis				Anne Arundel			
52	Funeral		Social Security Number 6. S			ast birthday)	If Under 1 Year Months Days	If Under :	Min.	Date of Birth (Mon Day,	Year)	9. Birth	place (State or Foreign ntry)	
-	Director	To Be Completed by Funeral Director	578-44-5620 Apr 4, 1933 Elton, VA								on, VA			
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits											
	farylarylarylarylarylarylarylarylarylaryl										12X Yes 2 □ No			
	the N 28a-f		10e. Street and Number				10f. Zip Code			11	On Citizon	of What Cou		
	with a or		2619 Nemo Ct				20716				og. Oliizeii c	or what cou	USA	
	ns 23 mus		11. Marital Status	er in U.S	S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. F	Race - Ameri	can Indian.			
	fter of the liner		1 ☐ Never Married 2 ☐ Married	1 X Yes 2 No								Black, White, etc. White		
8	ursa al', o Ex.m		3 ☐ Widowed 4 A Divorced				1 ☐ Yes 2 ☑ No Specify:				Specify: WILLE			
Q	should be filed within 72 hours after death with the Maryland and Mental Hyglene. In marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Eximiner must be notified at		15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working					6b. Kind of Business/Industry		
2	thin 7 an "r		Elementary/Secondary (0-12)	College (1-4or 5+) 4		life. DO NOT use retire		ed)		MAGA				
7	ed wi				4	Aeror	nautical	Engin	eer		NAS	A		
p	tal Hydra doth		17. Father's Name (First, Middle, Last)						,	e (First, Middle, Maiden Surname)				
Уa	Men arke		Everett I. Fogle, Sr.				Hilda Rothgeb							
Jar	2 sho		19a. Informant's Name/Relationship (g Address (Street						o Code)	
<u>ح</u>	es 1 and 2 of Health item 27 i		Lynette Stetson/	daughter	Look Di		Brookside							
Ö	Pages 1 nent of H ant; If iter ary or oth		20a. Method of Disposition 1. Burial 2 □ Cremation 3 □	Removal from State	1		sition (Name of natory or other pla		Date	'		on - City or T		
Baltimore, Maryland 21215-0036	. Pa tmen tant; tant		4 Donation 5 ☐ Other (Specif		Fort		oln Cemet							
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Ex miner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home											
	© □ = @ 0		Jon Romen - Charles 3401 Bladensburg Rd., Brentwood, MD 20722											
п			23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											
	Physician		Immediate Cause (Final disease or condition a. Septimental disease or condition											
	/Medical Examiner		resulting in death)	Due to (or as a	9									
	*	-	Sequentially list conditions,	onie										
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. The Unoduly Cause (Disease or injury that initiated events	uence of):						30				
	and and	xan	that initiated events resulting in death) Last C				ence of):							
9	be e sician buria	Physician/Medical E												
68760,	rtificate be executed ng physician and sas the burial-transit			d										
ŏ			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pt	f pregnar	псу					23d	Date of deliv	ien/	
ŏ	The law requires that the death ce tte has been signed by the attendii bage 2 should be detached for use		in the past 12 months?	death 3□					Month Day Year					
<u>о</u>	the o	ηλs	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)											
	s that ned k	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute							ontribute to	the cause of death?			
ğ	quire; n sig ald bu		Stage IV follicular lymphona 1 Yes 2 No							o 3∏Pro	3 Probably 4 Inknown			
S	w re	Completed	autopsy performed?						n 24	24b. Were autopsy findings available prior to completion of cause of death?				
æ	he la e has age 2	E G							sy					
Vital Records,			OF Was associated to medical								200 No			
	Attending Physician: The Ir death. ector: After this certificate he by the funeral director, page	To Be	examiner? Hospital: A Citier Office of Seatth Torock only only									(6.)		
Division or	g Ph er thi eral (4 Intuising nome 5 Inesidence 6 Uniter (Specify)								iy)			
<u>o</u>	ath. r: Aft e fun	ţį	1 Injury Work? 2 □ Accident investigation (Month, Day Year) Injury Work? 1 □ Yes 2 □ No											
N S	or Attendater death	ifica	3 Suicide 6 Could not be determined	Zoe. Flace of Illjury	y - At hor	ne, farm, str				Location (St	Street and Number or Rural Route Number,			
	al or s afte al Dir	Certification:	E 4 ☐ Homicide building, etc. (Specify) City or Town,						i, State)	State)				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	the H in 24 the F iplete	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	Vith To 1	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)											
)	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Point) Tim Worm's 2051 Medical Parkury Unnapoli; MD 21401											
	2		30. Name and address of person who	_		/ \	Print)	/		4	1			
			1/m Worms	2061	me	dial	Ar	cur	y li	mape	lis	mo	21401	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s Signati	Brest	b .	,						
	negistr	वा	AUG V I EVO	William	M	1								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items of Maryland Department of Health and Mental Hyglene

1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Marjorie Marie Grove Year MARGORIE MARIE 4, GROVE Aug. 2007 12:56 PM /Medical 4a. Facing lang (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20127 Pond Run Road Westover Somerset If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months 1 □ M 2 □ Yrs. Director July 001-18-6125 Iowa Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f shoy other traumatic svant. The Mudical Examiner must be notified at 1 Yes 2 No Directo Md. Somerset Westover 10e. S29123 umber 10f. Zip Code 10g. Citizen of What Country? ō 28127 Pond Run Road 238 21871 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Iter Important: or the marked other then "natural", or Iter and injury or other traumatic svent, Ite Modical Examine 2009. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ₩idowed 4 Divorced Specify: White Be Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 none Clerk Medical Records Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jerry rich Rachel Jones ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karl Kauffmann /Son 28127 Pond Run Road, Westover, Md. 21871 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory * 4 □ Donation 5 □ Other (Specify) 08/06/07 Salisbury, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral home 11673 Somerset Ave, Princess Anne, Md. 21853 mais 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy č in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient Other - P P 1 ☐ Yes 2 No 2 ER/Outpatient 4 Nursing Home 5 Residence 6 □Other (Specify) this 3□ DOA neral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury I Director: Afted in by the fund Natural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide n 24 hours at la Funaral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely within 2 To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 00 252 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Stegman, MD, 30434 Mt. Vernon Road, Princess Anne, Md. 21853 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 9 2007 Registrar

State Registrar

100 E. CARROLL ST. SAlisbury Md 21801 ANGDAMA MD VARAI) ARA JAN

AUG 0

31. Date filed (Month, Day, Year) 2007

32. Registrar's Signature

			1 - For State Registrar	State of Maryland / Department of Health and Mental Hygiene Certificate of Death									
	Physic /Medi		1. Decedent's Name (First, Middle, L Eleanor	Н.		Hughes		2. Date of Dea Month	Day Year	3. Time of Death			
	Exami	ner	4a. Facility Name (If not institution, gi SALISBURY REHAB	a. Facility Name (If not institution, give street and number) SALISBURY REHAB & NURSING C			4b. City, Town, or Location of Death SALISBURY, MD.		4c. County of Death WICOMICO				
	Funeral Director		5. Social Security Number 6. 220-10-9790 Usuel Residence of Decedent	Sex 1□M 2⊠F	7. Age (In yrs. last birthday) ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Port) 1			Year) 9. Birthplace (State or Foreign Country) Delaware					
	death with the Maryland ms 23a or 28a-f show Frodal to rediffed at	_	10a. State 10b. County		c. City, Town or Lo					10d. Inside City Limits			
_	the M.	Director	MD Wicomi 10e. Street and Number	co S	Salisbury	10f. Zip Code			l 0g. Citizen of What Cou	1X□Yes 2□No			
7	h with		611 Tressler Dri	ve		2180	1		USA	iuy r			
380	hours after death with the Marylar turel; or Items 23a or 28a-f show al Exeminer must be incitited at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:				Specify Yes or No- to Rican, etc.)		etc.			
21215-003	"na"	Completed	15. Decedent's E (Specify only highest gi	Education rade completed) Colfege (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo	rking	16b. Kind of Business/In	dustry			
		Con	12 17. Father's Name (First, Middle, Las		Hom	emaker			Own Home				
Maryland	a la b	To Be	Herman Holmes Ho	_			Annie B	me <i>(First, Middle, I</i> ailev	Maiden Sumame)				
lary	a e a		19a. Informant's Name/Relationship		19b. Mailin	g Address (Street			r, City or Town, State, Zip	Code)			
Baltimore, N	ges 1 an it of Heal if item 2 or other		Charles B. Hughe 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [☐Removal from State	Ob. Place of Dispos cemetery, crem	sition (Name of natory or other place	Θ)	Date	oron, Maryla 20c. Location - City or To	own, State			
altin	permit. Pa Departmer Important: any Injury		4 □Donation 5 □Other (Special Special		icomico N				alisbury, Ma eral Home	aryland			
	80 E 9 9		21. In grature of Facility Bounds Funeral Home 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Parts. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
68760,	he death certificate be executed by Action and the attending physician and the attending physician and the burial-transit contacts as the burial-transit.	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a co	nsequence of):	es es	1000			Onset and Death			
P.O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 1	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year			
	w requires that the de been signed by the a should be detached f	Ď.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco							co use contribute to the cause of death? 2 4 00 3 Probably 4 Unknown			
	The law ate has b page 2 si	Completed						24a. Whas ar autops perform 1 Yes 2	y prior to cor	osy findings available inpletion of cause of			
Vital	Physicien: this certificinal director,	Be	25. Was case referred to medicaf examiner?	9)	20110								
of	g Physie er this eral dir	5	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatient		4 LEMUTSING H	ome 5 Reside	nce 6 Other (Specify	1)			
Division	To the Hospital or Attending Physiking A bound and the Catal To the Funeral Director: After the completely filled in by the tuneral	Certification:	1 ☐Năturaf 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No						reet and Number or Rura	and Number or Rural Route Number.			
	Me Hospita 24 hours 16 Funerel 16tely fillex		29a. Certifier 1 2 Certifying Ph (Check only one) 2 Medical Exam	nysicien: To the best of my niner: On the basis of exar and manner stated.	knowledge, death mination and/or inve	occurred at the timestigation, in my op	e, date and place inion, death occu	, and due to the ca rred at the time, da	use(s) and manner as st ate and place, and due to	ated. the cause(s)			
	Vithir To th comp		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)							Date signed (Month, Day, Year)			
,	- and												
5	174		30. Name and address of person who WILLIAM ROBINS,				DA WD	21804	10/				
	Sta Registr		31. Date filed (Month, Pay, Year)	200 32. Registrar's S		DRUIDDUE	ZT \ EID •	21004					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Harry Bruce Hendershot 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) March 11, 1953 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)

WV 7. Age (In vrs. last birthday) Months Days Hours Min. 1 DM 2 □ F 54 Yrs. 218-62-8176 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2√ No Director Washington Hancock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21750 USA 15024 Mountain Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🏌 No Specify. þ 3 Widowed 4 Divorced <u>Whi</u>te Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Truck Assembly Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eva Shaffer James Clyde Hendershot 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Laurie A. Hend</u>ershot/Wife 15024 Mountain Road Hancock,MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Buck Valley Christain 08/16/07 Warfordsburg, PA 21. Sanature Funeral Service Licen ee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): NEUTROPENIA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): PANCYTOPENIA Due to (or as a consequence of): CHRONIC MYELOMONOCYTIZ LEUK EMIA IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? INFECTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably HEPATITIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CONGESTIVE HTPGRTENSION FAILURE 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

/Medical Examiner attending physician and for use as the burial-transit Box 687606 ed by the a detached f P.O. Records, Division or Vital this After To the Hospital or Attendia within 24 hours after death. To the Funeral Director; A completely filled in by the fu death.

Examine Physician/Medical þ Completed Certification:

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be no

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is.

Physician

6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address or person who completed cause of death (Item 23a) (Type, Print)

ANTAKO-WIR GOU

E. ANTIERM ST. HAMKISTOWN 251

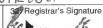
10062006

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 2 1 2007

DAVID



7-05985 dam Dar	niel Ho	llada	State of Maryland / Departr	ment of Health and Mental F	
				icate of Death	Reg. No.
	nysicia	ın/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year August 4, 2007 3. Time of Death 2007 hrs
ral I	Exami		Adam D. Hollada, Sr. 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	
			Lovett Drive @ Airport Road	Elkton	Cecil
Fu	neral		5. Social Security Number 6. Sex 7. Age (In yrs. last t		
Dir	ector		216-13-3183 1xm 2 F 22	Yrs. Months Days Hours Mi	November 8,1984 mty) MD
	Α.	ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Location	10d, Inside City Limits
	ow any			E1kton	1 X Yes 2 No
arylane	28a-f show I at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
the M	23a or 28a-f sho notified at once.		39 Maple Ct.	21921	U.S.A.
h with	ms 23 be no	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S	
er deat	or ite	Fun	1 X Never Married 2 Married 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:	Specify: White
urs afte	tural" umine	à	or Dates:	a. Decedent's Usual Occupation (Give kind of	work done 16b. Kind of Business/Industry
5 72 hor	n "na al Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re	
Mithin	er than "	dmc		Pallet Jack Opera	tor Restaurant ne (First, Middle, Maiden Surname)
21215-0036 uld be filed within 7	al Hyg ed oth	Be C	17. Father's Name (First, Middle, Last) Michael D. Hollada		nda Spandler
212 ould be	Ment mark ic ever	ToB			Rural Route Number, City or Town, State, Zip Code)
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland	Ith and n 27 is numati		Michael D. Hollada/Father		
ore,	of Hea If iter her tra		1 Removal from State crer	ce of Disposition (Name of cemetery, matory or other place)	Date 20c. Location - City or Town, State
time Page	tant:		4 Donation 5 Other Specify:	cton Cemetery 2	E1kton, MD
Ball permit	Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Andrew G. Gee	Funeral Home
	sician		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate Interval Between Onset and
	edical miner		Immediate Cause (Final disease a. Multiple Injuries		Death
			or condition resulting in death) Due to (or as a consequence of):		
		Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
ĺ.		Examiner	Clisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
executed	ian and ial - transit		d		
), be exe	sician urial -	dica	UNPENDED AMENDED		, elevent
Box 68760,	signed by the attending physic be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant 1 Live birth	ncy 2 Fetal death 3 Ectopic preg	23d. Date of delivery nancy Month Day Year
X 6	ttendir r use a	sicia	past 12 months? 1 Yes 2 No 9 Unknown 0 Unknown	Other (Specify)	
. Bc	y the a	Phys	aa	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O. Ial or Attending Physician: The law requires that th	gned b e detac	by	Talk in Street agreement services	g,gg	1 Yes 2 No 3 Probably 4 Unknown
r ds, require	has been si 2 should b	etec			24a. Was an autopsy lindings available prior to completion of cause of
ecol	te has ige 2 sl	Completed			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
<u>≅</u> ≅	certificate has been ector, page 2 should	Be Co	25. Was case referred to medical	26.Place of Death (Chec	ck only one)
Vit.	After this c uneral dire	To E	1 V Yes 2 No		sing Home 5 Residence 6 V Other: Scene 28d. Describe how injury occurred
n of	h. Afte funer		(Month Day Year)	8b. Time of Injury 28c. Injury at Work? 1 Yes 2 ✓ No	Driver all terrain vehicle fixed object collision
isio Atter	er deat rector i by th	icat	2 Accident Investigation 28e. Place of Injury - At hom	e, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
ital e	urs aft ral Di illed ir	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street		or Town, State) Lovett Drive west of Airport Road, Elkton, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be	within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To the best of my knowledge, one) 2 ✓ Medical Examiner: On the basis of examination and	, death occurred at the time, date and place, a	nd due to the cause(s) and manner as stated.
To th	withir To th compl	Medical	one) 2 ✓ Medical Examiner: On the basis of examination and and manner stated. 29b. Signature and title of pertifier	29c. License number	29d. Date signed (Month, Day, Year)
		2		O.C.M.E.	August 5, 2007
			30. Name and address of person who completed cause of death (Item 2:		
1			Susan Hogan MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD	21201
	S	tate	31. Date filed (Month Par Year) 8 2007 32. Redistrar's Signature	4 Araile	

Registrar

			For State Registrar	Sta	ate of I	Marylar		artmen rtificat			and M	ental Hy	giene Reg. No.		t no. of))
257	hysici		1. Decedent's Name (First, Middle Esther S. Hop)									2. Date of De Month	ath Day	2007	3. Time o	of Death A M
	/Medic xamin	_	4a. Facility Name (If not institution Genesis Elder	care Se	evern	a Park		Se	evern	Location o	ck		4c. C	ounty of Dea	undel	
Dir	neral ector		5. Social Security Number 296-16-4178 Usual Residence of Decedent	6. Sex 1 ☐ M 2		Age (In yrs.	last birthday) Yrs.	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da June 1	y, Year)	11	thplace (State ountry)	or Foreign
Maryland	a-t show	ctor	MD 10b. County Anne	Arunde	el		y, Town or Lo Severna		.		, , , , ,				10d. Inside C	City Limits
ith with the	ust be not	ai Director	10e. Street and Number 7 Sunset Drive	9				10f. Zip	Code 21146				_	en of What C	ountry?	
ING 21215-0036 be filed within 72 hours after death with the Maryland tall Hyglene	s markad one than natura, or rama 23s or 25s-1 show aumstic event, the Madigal Exempler must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	ned 1 [as Decede med Force Yes 2[Yes, Give ear or Date	ΧNο		Was Decect f Yes, spec l ☐ Yes		panic Orig , Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No Rican, etc.)		4. Race - Ame Black, Whi Specify: V		
Maryland 21215-0036 to 2 should be filed within 72 hours af th and Mental Hygiene.	the Mudical	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	Ť		or 5+)	life. I	lent's Usua kind of woi DO NOT us creta	rk done di se retired)	uring most	of workir	ng		of Business	Industry Educat	ion
	atic event,	To Be C	17. Father's Name (First, Middle, Leander Simps							Alir	ne Ho	(First, Middle, offman	Maiden S	lumame)		
2 ટૂક્	other traumatic		19a. Informant's Name/Relations Theodore R. Ho		•		7 Su	nset	Driv			Route Numbera Na Park				
			20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other (S	pecify)	al from Sta	te C	Place of Dispo emetery, cren etro Cr	natory or o	ther place			st 03,		ation - City or		
Dermit.	any injury or	_	21. Signature of Juneral Service	SKI	len	/	E 4		ov. R	Sons itchi	ie Hw	A. Sev		Park F Park,	uneral MD 2114	Home 46
Physi /Me Exan	dical		23a. Pafi1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	se on each	line.	EUN		,	, such as o	cardiac oi	r respiratory ar	rest,		Approximatinterval Bet Onset and	tween
ate be executed	s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C		as a consequ										
the death certif	or use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	10	Live birth	ne of pregna 2 □ Fetal at time of de	death 3	Ectopic pre					23	d. Date of de Month		Year
The law requires that	peq	<u>م</u>	Part II. Other significant condition	ons contributi	ng to death	but not resu	ulting in the ur	derlying ca	ause giver	n in Part I.			obacco use		the cause of cobably 4	death? Unknown
	page 2	Completed								 		24a. Was autop perfor 1 Yes	sy	24b. Were au prior to death?	stopsy findings completion of c	available ause of
Of VICAL Physician: '	-	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 No	Hospita	1 🗀 Inpa		ER/Outpatien		A Other	· 4 Nur	sing Hor	(Check only o	lence 6 (cify)	
ding -	fune	Certification:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could	g gation not be	Month, L	Day Year)	28b. Time of Injury	М		es 2 N	lo	8d. Describe h				
To the Hospital or Attendituding 24 hours effer death	filled in by		4 Homicide determ		building,	etc. (Specify						8f. Location (S City or Tow nd due to the o	in, State)			iber,
o the Hos ithin 24 h	ompletely	Medical	(Check only 2 Medical one) 29b. Signature and little of certifie	an	n the basis id manner:	of examinat stated.	tion and/or inv	estigation,	in my opi	nion, death	n occurre	d at the time, o	date and p	lace, and due	to the cause(s	
W/	De	7	1/mil	111	M	Um (MA		1)31	136	, ,	- RD /	Au	sust	2,20	07
	Ste.	0	30 Nam: d addre s of person	WA(CAC	tr r's Signal	ture (Type F	205	Kie	BR	100	ED, 1	BAUT	MOL	Sug ?	1236
R	Stat egistra		AUG 0	2007	Me	her ,	K 4	mile	•			1				

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	1. Decedent's Name (First, Middle, Last)					2. Date of De	n a dla		3. Time of Death
	1. Decedent's Name (First, Wildlie, Last)					Month	Day	a a Xeer	
in al	Adrian	S		Hall		August	_	2007	
~, <u> </u>	4a. Facility Name (If not institution, give street a			4b. City, Town, or		ath		County of Dea	
_	Southern Maryland		(m = 4 ft (= 4 ft = 4 m = 1)	CLi	nton	rs 0 Data of Bi			Seorges
1	5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) _ Yrs.	Months Days	Hours Mi	n. (Month, Da	ay, Year)	C	thplace (State or Foreigountry)
-	Usual Residence of Decedent	51				01/1	1/19	56 Was	hington I
ŀ	10a. State 10b. County	10c. City	, Town or Loc	ation					10d. Inside City Limit
힏	Maryland Prince Ge	orges F	3randy	wine					1 XYes 2 □ N
rec	10e. Street and Number	01905 -		10f. Zip Code			10g. Citiz	zen of What C	ountry?
Funeral Director	12609 Cedarville R	5 so		2061	13			USA	
era	11. Marital Status 12. Wa	s Decedent Ever in U.	S. 13. W			(Specify Yes or No erto Rican, etc.)		14. Race - Am	
ᆵ	1 ☐ Never Married 2 ☐ Married 1 ☐	ned Forces?]Yes_2 ∑ No				erto Hican, etc.)		Black, Whi	
۵		es, Give ar or Dates:	1	☐ Yes 2 XNo	Specify:			Specify:Bla	ack
Completed	15. Decedent's Education (Specify only highest grade comp.	leted)		ent's Usual Occup		vorkina	16b. Kir	nd of Business	/Industry
ם		lege (1-4or 5+)	life. D	O NOT use retired))	rorking			
5	12		Equip	ment Op			·		nstructio
Be (17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle	, Maiden	Surname)	
၉	William		Hall		Maria	า			Makle
	19a. Informant's Name/Relationship (Type. Prin	nt)	19b. Mailing	Address (Street	and Number or	Rural Route Numb	ber, City o	r Town, State,	Zip Code) 20613
	Beverly Saunders/					Rd. Bra	ndyw	ine,Ma	aryland
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova	20b. P	lace of Dispos emetery, crem	ition (Name of atory or other plac	ce)	Date	20c. Lo	cation - City or	r Town, State
	4 Donation 5 Other (Specify)	Re	surre	ction	08	/09/07	Cli	nton,M	laryland
	21. Signature Funeral Service Licensee	1	22.	Name and Addres	ss of Facility	Adams F	uner	al Ho	me PA
	Lloya Cet	5	191 20	605 Aqu					land 2060
						ing or recognizations	arrest,		Approximate
	23a. Part1. Enter the disease, or complications	that caused the death	n. Do not ente	r the mode of dyin	g, such as card	iac or respiratory a			Interval Between
	shock, or heart failure. List only one caus Immediate Cause (Final	se on each line.						\sim	Onset and Death
	shock, or heart failure. List only one caus Immediate Cause (Final disease or conditionaa	se on each line.						٧	
	shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	se on each line.						٧	
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3. Time of Death

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

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and lealt m 27	9	Margaret L. Harmon/Friend 425 Pleasanton Rd Westminster, MD 213 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery crematory or other place) Date 20c. Location - City or										·	_			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2	•	3 □Remova	I from State	CE	emetery, cre	on Park Cemetery 8/8/2007 Baltimore, MD								
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pita Surs leral fillec		29a. Certifier	1 Certifyir	ng Physician:	To the bes	st of my know	wledge, dea	th occurred at the	time, date	and place.	and due to the	cause	(s) and mann	er as s	tated	-
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to	edical	(Check only one)		Examiner: O		of examinat		nvestigati <i>o</i> n, in my								
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PAINA		30. Name and add	ress of person	who complete	ed cause of	death (Item	23a) (Type	Print)	ANE	E, W	ESTM	1~	STER	1	10 S112	7
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Timothy Steven Hall 0848 July 31, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1**√2**M 2□ F 47 Months Days Director <u> 213–78–2905</u> August 1. Washington, D.C. Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√2Yes 2 No Prince George's Maryland Landover Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? th and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 20785 1401 Belle Haven Drive U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z Mylo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 14 Never Married 2 Married 1□Yes 2ŽNo Baltimore, Maryland 21215-0036 Specify: Black þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Green's Transportation Elementary/Secondary (0-12) College (1-4or 5+) Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie B. Newell Ann D. Thomas P 19a. Informant's Name/Relationship (Type. Print)
Ann D. Hall (Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401 Belle Haven Drive Landover, Maryland 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation ö 3 ☐Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc. August 8, 2007 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 23a. 7a.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ending physician and use as the burial-transit Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ρ in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ned by the a e detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XUnknown Completed 24a. Was an certificate has be irector, page 2 s autopsy performed 1∐ Yes 2 No the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: To the

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 25 No Certification: To 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tiffe of certifier D58957 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hererly MA 20785 3001 HOSDHA DY: Lang 31. Date filed (M 32. Registrar's Signature State Registrar **ORIGINAL**

DHMH 17 Rev 1/2001

		For State Registrar	ease i			nd / D	epartn		Health and	Mental H		e_ (14.7	26367
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Funeral	er	4a. Facility Name (If not instituted in the state of the	re Nu	rsing	Home 7. Age (In yr.		H;	yattsv Jnder 1 Year nths Days	If Under 24 H	irs. 8. Date of E in. (Month, I	Printh Day, Year		orge's place (State or Foreign intry)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	578-22-5849 Usual Residence of Deceden 10a. State	ce Ge Road	orge s	edent Ever in orces?	city, Towr	or Location ville	of. Zip Code 20782		Jan 20 (Specify Yes or Nerfo Rican, etc.)	10g. C	itizen of What Cou ted State 14. Race - Amer Black, White	es ican Indian,
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eath certificate be executed attending physician and for use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	Due to	or as a conse	equence on Fai	of): Llure						Months Months
the death certificat y the attending phy ached for use as the	Physician/Medi	d					3 ☐ Ectopic pregnancy 5 ☐ Other (specify)					23d. Date of deli	very Day Year
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lan; The l rtificate ha	Be Com	25. Was case referred to me examiner?	dical						26. Place of D			death?	ompletion of cause of 2 ☐ No
To the Hospital or Attending Physiclan: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Certification: To E	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pe 2 Accident inv 3 Suicide 6 Co		28a. Date (Moi		28b. 7	tpatient 3 Time of hjury M rm, street, f	28c. Inju Wo	ıryat ork?]Yes 2∐No	28d. Describ	e how inj	and Number or Ru	
24 hours a Funeral stely filled	Medical Ce	29a. Certifier (Check only one)	ifying Phy ical Exam	ner: On the	e best of my k basis of exami	nowledge nation an	, death occ d/or investi	urred at the gation, in my	time, date and pla opinion, death o	ace, and due to the courred at the time	ne cause(e, date a	s) and manner as nd place, and due	stated. to the cause(s)
To th within To th coπpl	Me	29b. Signature and title of ce	tifier) 0			29c. Licen	se number		29d. D	ate signed (Month	n, Day, Year)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Raman R. Tuli, M.D. 3503 Perry Street, Suite B- Mt. Rainier, MD 20712

31. Date filed (Mantham Trear)

32. Registrar's Sanature

D19609

August 1, 2007

			1 - For State Registrar	State of M	•	partment of F ertificate of			ene g. No.	40.
			Decedent's Name (First, Middle)	e, Last)				2. Date of Death		3. Time of Death
	Physici		Margar	et Marie Jac	ckson			Lucust	Day Yeer	10:00 AM
	/Medic Examin		4a. Facility Name (If not institution	, give street and number)		4b. City, Town, o	or Location of Death	1)	4c. County of Deat	
		-	1485 Jacob T	ome Highway		Port	Deposit		Ce	cil
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birthd	ay) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		hplace (State or Foreign
	Director		213-16-9091	1□M 2QF	85 Yrs	Months Days	Hours Will.	May 24,	1921 M	aryland
	2		Usual Residence of Decedent		T. 0					
	ahow da	_	10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits 1 ☐ Yes 2X No
:	Ba-1 a	cto		cil		Port	Deposit			
	ith th	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	23e		1485 Jacob Tom				21904		U.S	
	er de teme	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	or l	by F	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	No	1 ☐ Yes 2 ☐ No	Specify:		Specify:	White
2-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. The Hygiene. The Hygiene 124 or 28a-f ahow marked other than "natural", or itema 23a or 28a-f ahow maric event, Ira Madical Examiner must be notilied at	pe p	15. Decedent	Year or Dates:	162 00	cedent's Usual Occup	antico	1	6b. Kind of Business/	
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2	filed with Hygiene. other than		17. Father's Name (First, Middle,	Last)			18. Mother's Name	e (First, Middle, M	aiden Sumame)	
an	Mental Mental arked o	To Be	Jan	nes Gorrell				Cecilia	Moore	
Maryland	2 should and Meni Is marke aumatic	F-	19a. Informant's Name/Relations		19b. M	ailing Address (Street	and Number or Rura		City or Town, State, 2	Zip Code)
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<u>ი</u>	jes 1 and 2 should of Health and Men if Item 27 is marke or other traumatic		20a. Method of Disposition	,	20b. Place of Di	sposition (Name of			0c. Location - City or	
altimore,	permit. Pages Department of I Important: If Its any injury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)			crematory or other pla ast Method		7/07 No	orth East,	Marvland
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			shock, or heart failure. List Immediate Cause (Final	only one cause on each I	The second secon	+ + 1				Interval Between Onset and Death
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m i	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 💆 No	4☐Pregnant a		5 Other (specify)	у		Month	Day Year
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Ś	The law requires that the de ite has been signed by the a page 2 should be detached to	by F	Part II. Other significant condition	ons contributing to death t	out not resulting in th	e underlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	
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Vital Records,	The la	Completed						perform	ed? death? XINo 1 □ Yes	·
<u>.</u>	Physician: Th this certificate ral director, pag	Be C	25. Was case referred to medical				26. Place of Death	h (Check only one		
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Division of	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date of Inju (Month, Da	ury 28b. Tim uy Year) Inju		ry at rk?	28d. Describe how	v injury occurred	
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<u>Š</u>	or Attendate after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 289. Place of in	jury - At home, farm, tc. (Specify)	street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
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	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director. After this certifica completely filled in by the funeral director,	edical	(Check only 2 Medicel	g Physician: To the best Exeminer: On the basis of	of examination and/o	eath occurred at the till r investigation, in my o	me, date and place, ppinion, death occurr	and due to the cau	use(s) and manner as te and place, and due	stated. to the cause(s)
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	K		30. Name and address of person	who completed cause of	death (Item 23a) (Ty	pe, Print)		1+ -11.	+	
			31. Date filed (Month, Day, Year)	1 3616	rar's Signature	e 133N.	Midge	51. Elk	10h, 17	21921
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amended item #6/wico/map/8-7@06fjcate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** TON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional medicar Cente NICOMICO If Under 1 Year | If Under 4 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 86 Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No A. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 3 by Funeral 14. Race - American Indian Black, White, etc. Was Decedent Ever if U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Pres 2 No 1942 Mes, Give Year or Dates:) 941 Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Maryland 21275-0036 "natural", or 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ason 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 traumatic reorge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: If item 27 any injury or other tr hette rence (daughty Coal 1 hornburg Koad Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Durial 2 □ Cremation 3 Removal from State 22. Name and Address Facility 4 ☐ Donation 5 ☐ Other (Specify) lerusale 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician occordia /Medical Due to (or as a consequence of) **Examiner** ronac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine rabetes The law requires that the death certificate be executed UNKNOW burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ension 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy
performed?

1 Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1√Z Natural 5 Pending investigation Injury 1 Tes 2 No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08/05/07 D63499 Au. 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) NAISUN NIND 12137 Elm Street PrincessAnne MD 31. Date filed (Month, Day, Year) AUG 07 32. gistrar's Signature State 200 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:15 A M July 28 2007 Larnell Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Prince George's Washington Adventis Hospital 8. Date of Birth (Month, Day, Year)
Tune 191941 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 228-52-7543 66 Virginia Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits show a or 28a-f show be notified at XXYes 2 □ No DC Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3219 9th Pl SE 20032 U.S.A. items 23a Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Maryland 21215-0036 'natural', or 1 ☐ Yes 2√2 No Specify. Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Larnell Johnson Mary Christian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha Tucker 5410 Winston St. Temple Hill 20748 Md Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Ouantico Vet. Cem Quantico ۷a 2007 22. Name and Address of Facility McLaughlin Funeral Home 21. Signature of Funeral Service Licensee 2019 MLK Jr. Ave SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner UNG CANCER The law requires that the death certificate be executed METASTATIC attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) signed by the ald 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☎No 24a. Was an ate has bage 2 s autopsy performed 2 No al or Attending Physician: 3 after death.
Il Director: After this certifical ed in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 24 hours a To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 and manner stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ΜŊ s of person who completed cause of death (Item 23a) (Type, Print) 732 CHAKA PARKWAY GREGIBELT MARYLAMS -5A HARY OVER 31. Date filed (Month, Day,) AUG 0 32. Registrar's Signature State

Registrar

07-06244 Curtis Klentzman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Our no reconazina		I- For State Registrar	Or Ivial ylariu		cate of Death	iu Meritari		g. No.	17 2507
Physicia	an/	 Decedent's Name (First, Middle, La 					Date of Deat Month	h Day Year	3. Time of Death
Medical Exami	ner	CURTIS LLC 4a. Facility Name (If not institution, gi		LENTZMA		or Location of Dea	August 13	, 2007 4c. County of Deat	1824 hrs
		2400 Pinefield	re street and number,		Waldorf	or Location of Dea		Charles	"
Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. last b				th(MM/DD/YYYY) 9. Bi	
Director			M 2 F	50	Yrs. Months Da	ys Hours M	07-23-	1957 Forei	ountry) WASH. DC
N	ev red	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location		` `		10d. Inside City Limits
and show nce.	٦	MARYLAND CHARLE	S	L v	W	ALDORF	Tri of		1 X Yes 2 No
th the Maryland 23a or 28a-f show	rect	10e. Street and Number			10f. Zip Code		10	og. Citizen of What Cou	•
h with the Mary	Funeral Director	2400 PINEFIELD RO		Fundin H.C.		0601	Canait Vas al Na		D STATES
eath w	ner	1XX Never Married 2 Marrie	12. Was Decedent Armed Forces 1 XX Yes 2		13. Was Decedent of H			White, etc.	rican Indian, Black,
after d	by Ft	3 Widowed 4 Divorce	d If Yes, Give Year	No	1 Yes 2XX N	o specify:		Specify:	WHITE
hours		15. Decedent's Education (Specify of			a. Decedent's Usual Occup during most of working life	ation (Give kind of	of work done retired)	16b. Kind of Business	/Industry
36 hin 72 e. than "	Completed	Elementary/Secondary (0-12)	College (1-4 or 4	5+)	SECURITY	OFFICE	2	SECUR	ITY
215-0036 be filed within 72 ttal Hygiene. *ked other than "	Con	17. Father's Name (First, Middle, Las	t)				me (First, Middle, M		
121 d be fil ental I	Be	JAMES FINLEY KLEN					AH ALICE		
Baltimore, MD 21215-0036 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mertal Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relationship (CHRIS A. KLENTZMA		1.00	9b. Mailing Address (Stre 1010 BROWARD				
rre, l s 1 and f Healt lf item		20a. Method of Disposition 1 Burial 2 X Cremation 3	Removal from St		e of Disposition (Name of catory or other place)	emetery,	AÜĞ.	20c. Location - City o	r Town, State
Page Page hent o lant:		4 Donation 5 Other Specif	/:	HUN	TT CREMATORY]	19, 2007	WALDORF,	MD
Baltimore, permit. Pages I an Department of Hee Important: If ite		21. Signature of Funeral Service Lice	M O O	00053	22. Name and Addre			ERAL HOME WALDORF, M	D 20601
Physician		23a. Part I. Enter the disease, or comfailure. List only one cause on e		the death. Do					Approximate Interval Between Onset and
/Medical Examiner	ı		. Hypertensi		ovascular disea	se			Death
		Sequentially list conditions,	Due to (or as a cons	equence of):					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cons	equence of):	C. P. Y. I	.100	ou ma.		_1
cecuted nand transit		events resulting in death) Last	Due to (or as a cons	equence of):					
riar e	Medical	UNPENDED	AMENDED #23a PTT 2	7.perME.0	0871, 9/4/07 TT				
3760, ficate b g physic s the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	me of pregnanc	;y		nancy	23d. Date of delive Month	ny Day Year
Box 687 e death certific the attending p	iciai	past 12 months?	4 Pregnant at	time of death	Fetal death 3 Other (Specify)		griancy	Month	Day Teal
Bo he deal	Physician/	1 Yes 2 No 9 Unknow	9 OHKHOWH				LOGO Biddo		the serve of death?
cords, P.O. Box 687 law requires that the death certific has been signed by the attending 2 should be detached for use as t	by F	Part II. Other significant conditions Alcohol use;		n but not result	ing in the underlying cause	given in Part I.		bacco use contribute to	obably 4 V Unknown
'ds, require seen sig ould b	Completed	Addition desc,	этеер арпеа				24a. Was		autopsy findings available
Recor The law : cate has t	du						autop perfoi 1 ✔ Yes	med? death?	
tal Recol		25. Was case referred to medical			26.Pla	ce of Death (Che		2No 1 🗸 \	Yes 2 No
Vita hysicis this ce	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2 ER/	Outpatient 3 DOA	Other Nur	rsing Home 5	Residence 6 🗸 Oth	er: Scene
Division of Vital Records, P.O. all or attending Physician: The law requires that the safer death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact		27. Manner of Death 1 X Natural 5 Pending	28a. Date of Inju (Month, Day,)	ary 28b (ear)		ury at Work? Yes 2 No	28d. Describe I	now injury occurred	
ivisior or Attend after death Director:	icati	2 Accident Investiga	28e Place of Ir	niury - At home.	farm, street, factory, office	3	28f. Location (\$	Street and Number or R	Rural Route Number, City
Div ospital or hours afte aneral Div y filled in	Certification:	3 Suicide 6 Could no determine	t be	,,	,		or Town, S		,
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical C		r:On the basis of exa		leath occurred at the time, r investigation, in my opinio				
To To	Me	29b. Signature and title of certifier	and manner stated.		29c. Licer	nse number		29d. Date signed (M	onth, Day, Year)
		Carol 1	falla	an		.M.E.		August 14, 200	7
SB			completed cause of cant Medical Exar	,) 1 P enn Street, Baltir	nore, MD 212	201		
St Regist	ate rar	31. Date filed (Month, Day Year)		r's Signature	Sparke				
					-				

DHMH 17 Rev 1/2001 OCME 2006

			1 - For State Registrar	State o	of Marylan		artment of tificate o				giene , Reg. No. ¹	2007	2507
ı	- Division in		1. Decedent's Name (First, Middle,	.ast)						2. Date of De Month	ath Day	Year	3. Time of Death
	Physici Medic			Lone						8	ų	"07	0747A M
	Examir	ner	4a. Facility Name (If not institution, g	ive street and nu	ımber)		4b. City, Town		of Death		4c. C	ounty of Deat	h
	100		Constal Hospice	At the	Lake		Salis	r If Under	0411			Com	
	Funeral		5. Social Security Number 6 221–18–6729	Sex 1□M 2XF	7. Age (In yrs. 78		If Under 1 Yes Months Day		Min.	8. Date of Birl (Month, Da	y, Year)	Co	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent		/0]]I	Dec. 1,	192	8 Mai	yland
	land ow st		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation	•					10d. Inside City Limits
	-f sh	호	MD Wicon	nico		Salisbu	ırv						1 ∐Yes 2X No
	r 28a	Director	10e. Street and Number			041100	10f. Zip Code	+			10g. Citize	en of What Co	untry?
	3a o		5312 Eastwood (Circle			218	02			U.:	S.A.	
	be filed within 72 hours after death with the Maryland ital Hyglene. od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U	.S. 13. \	Was Decedent of Yes, specify C	Hispanic Or	rigin? (Spec	cify Yes or No		4. Race - Ame Black, White	
0	after or ite mine		1 ☐ Never Married 2 ☐ Married		2 X No		ili Yes 2⊠XN			ilcari, etc.)	-	Black, White Specify: Wh	_
3-002g	ours raf.; Exa	d by	3 XWidowed 4 ☐ Divorced	Year or I	Dates:		100 2011	o opeany.					
ה	72 h 'natu dlcal	Completed	15. Decedent's (Specify only highest	Education grade completed,)	16a. Deced	dent's Usual Occ kind of work dor DO NOT use reti	upation e during mos	st of workin	g	16b. Kind	d of Business/	Industry
7	ithin ne.	臣	Elementary/Secondary (0-12)	College	(1-4or 5+)						т.,	mh an C	
V	e filed within 72 al Hygiene. other than "nai vent, the Medic		17. Father's Name (First, Middle, La	Z ot)		ъс	okkeepe		or's Name	(First, Middle,		mber Co	ompany
<u>8</u>	uld be fi fental H rked ot tic ever	Be	•							,		umame)	
5	2 should be and Mental is marked or raumatic ev	은	Ralph C. Cordre	-		10b Mailir	ng Address (Stre			lia Per		Town State	Zin Code)
2	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		Brenda Parsons	, ,,	hter)		2 Eastwo					y, MD	
נֿע	s 1 and 2 of Health a item 27 is other trau		20a. Method of Disposition	()			sition (Name of natory or other p			ate		ation - City or	
2	Pages nent of I int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		i State		natory or other p 1 Cemete	1	Q	, 2007	Dare	sonsbur	·α MD
Dallillor	artme ortan injur		21. Signature of Funeral Service Lie	**	1001					, 2007	lais	oonsour	g, rib
Ö	permit. Departr Importa any inju		F. Glwill	*		S	Name and Add hort Fu 3 E. Gr	neral ove St	Home De	lmar,	DE I	19940	
	4.5		23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that	caused the deat								Approximate
	Physician		Immediate Caus (Final										Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to	(or as a consec	uence of):	IERY	DI	SRF	12		-	
	Examiner			. 00	CONAIR (or as a consec NORS	TIUR	HRA	RT	FAi	uni	3_		
U.		je.	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	uence of):	,,,,						
	cuted nd ransit	Examine	that initiated events	c									
Ď,	e exe		resulting in death) Last	Due to	(or as a conseq	uence of):							
	the death certificate be executed y the attending physician and iched for use as the burial-transit	dical		d				·					
Ŏ	ng ph as t	Med	IF FEMALE:										
Š	ath ce tendi	an/	23b. Was decedent pregnant in the past 12 months?		utcome pf pregn birth 2 □ Feta]Ectopic pregna	ncy			23	3d. Date of del Month	ivery Day Year
	e deg	Sici	1 ☐ Yes ☐ No 9 ☐ Unknown	4□Preg 9□Unki	nant at time of one	death 5	Other (specify)					WOTH	Day Tour
Ċ	w requires that the death certifichen signed by the attending I should be detached for use as	Physician/Me	Part II. Other significant condition	e contributing to	death but not rec	ulting in the u	nderlying cause	niven in Port	1	23e Did t	ohacco us	e contribute to	the cause of death?
ń	requires that een signed b nould be deta	by	Tarti. Other algimicant condition	s contributing to	Journ But Hot 165	aning in the di	idenying dadac	giveninitait	1.	1[7]			robably 4 Unknown
Spics	requ	Completed									/		2-W-2
ภ	2 28	힡					-			24a. Was			topsy findings available completion of cause of
<u> </u>	: The cate had page	ខ								1□ Yes	Z No	1 ☐ Yes	9ERO
N 1	Physician: The law rthis certificate has tral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:					e of Death	(Check only o	one)		
5	Phys this al dir	은	1 Yes 2 No.	1 . (ER/Outpatier	I JU DON					□Other (Spe	cify)
	Ilng I After funer	io	1 Natural 5 Pending		nth, Day Year)	Injury	V	jurya≀ /ork? □Yes 2□		8d. Describe	now injury	occurred	
	Attending it death. ector After by the funer	icat	3 Suicide 6 Could no	be 280 Plac	e of injury - At h	ome, farm, str				8f. Location /	Street and	Number or Br	ural Route Number,
\	fter Direction by	Certification:	4 ☐ Homicide determine	build	ding, etc. (Speci	fy)	001, 120101), 01111			City or To	vn, State)	rediriber of Tie	sidi Houte Wallibol,
	To the Hospitalior Attending Physician: The within 24 hours: flee fleath. To the Funeral Director After this certificate he completely filled in by the funeral director, page		29a. Certifier Certifying	Physician: To th	e best of my kno	owledge, deat	h occurred at the	time, date a	ind place, a	and due to the	cause(s) a	and manner as	s stated.
	e Hox 24 h e Fur etely	edical		aminer: On the									
	Vithin Co the complet	Me	29b. Signature and title of certifier	<u> </u>			29c. Lice	nse number			29d. Date	signed (Mont	h, Day, Year)
	- > - 0			/_	, _		_ 0	005 8	1410		2	14/1	フ
9	u 2	3	30. Name and address of person w	no completed cau	use of death (Iter	m 23a) (Type.	Print)					, , , ,	
6,			CHULAM WAR			tospic	R Pi	BOX.	1732	SAL	isBu	Ry 1	7 up 21802
	Sta	ate	31. Date filed (Month, Day, Year)		Restrar's Sign		1					,	

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007

1007

Anne Arundel

14. Race - American Indian

White

Black, White, etc.

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

Specify:

3. Time of Death

9:07p

PA

1 ☐ Yes 2 No

10d. Inside City Limits

Approximate Interval Between Onset and Death

Minute

Birthplace (State or Foreign Country)

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Edward Philip Loftus Aug. 1, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1**X** M 2 □ F 73 177-26-4113 Director Jan. 11, 1934 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "marked" in any injury or other transmits. 10a. State 10b. County 10c. City, Town or Location MD Anne Arundel Annapolis Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 930 Beacon Way 21401 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🗗 No Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Government Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Defense 5+ Logistics Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be Edward J. Loftus Mary Hastings 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Ann Loftus/Wife 930 Beacon Way, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery Crownsville, MD 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Barranco & Sons, Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 PM. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 10card disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 diknown should Completed 24a. Was an page 2 s autopsy performed certificate 1☐ Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 3 DOA Certification: To 1 Inpatient 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation Injury 1 Natural s after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D l 🕰 😂 fitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 16964

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 0 6 2007

1- State of Mary
Neglistrar 8/8/07 AACO Health Dept CMH

1509

· Huy Arnois

DHMH 17 Rev 1/2001

State

Registrar

James 31. Date filed (Month, Day,

			1- For State of Maryland / Dep	eartment of Health and Nertificate of Death	, ,	ene g. No. O (117)	group as a group
	Physici /Medi		1. Decedent's Name (First, Middle, Last) MELVIN MCILWAIN JR.		2. Date of Death Month AUG •		3. Time of Death 11:58 PM
>	Examir		4a. Facility Name (If not institution, give street and number) 2217 ROSEDELL PLACE	4b. City, Town, or Location of Death FT • WASHINGTO		4c. County of Death PRINCE G	EORGES
15°	Funeral Director		5. Social Security Number 249-68-4046 6. Sex X2M 2□ F 6.4 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, MAY 18	rear) Cou	place (State or Foreign htry) HINGTON , D
	ne Maryland 8a-f show otified at	ector		SHINGTON			10d. Inside City Limits
	th with the 23a or 2 ust be no	al Dire	10e. Street and Number 2217 ROSEDELL PLACE	10f. Zip Code 20744		g. Citizen of What Cou J . S . A .	ntry?
920	72 hours after death with the Maryland ratural; or items 23a or 28a-f show digal Examiner must be notified at	by Funeral Director	11, Marital Status 1 □ Never Married X Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever In U.S. Armed Forces? 1 □ Yes 2 № No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 Who Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: BI	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) S TECHNICIAN	sing 10	6b. Kind of Business/In	dustry
and 2	d be filed ental Hygie set other c event, the	To Be Co	17. Father's Name (First, Middle, Last) MELVIN MCILWAIN SR.	18. Mother's Nam	e (First, Middle, Mi	aiden Surname)	
Maryland	d 2 shoul th and Mo 7 is marl traumati	ř	19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or Rull ROSEDELL PL.	ral Route Number,	City or Town, State, Zip	
Baltimore, I	bages 1 and ent of Healt it. If item 2	1	20a. Method of Disposition 1★ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition certain contents of the complex of the	osition (Name of ematory or other place)	Date 20	Oc. Location - City or Te	own, State
Baltir	permit. F Departme Importar any Injur		21. Signature of Funeral Service Licensee	NCOLN CEM. : 8/8 22. Name and Address of Facility St 5500 ALLENTOWN	TRICKLA		L SERVICE
531.4	Physician	18	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDITAL IN		or respiratory arres	st,	Approximate Interval Between Onset and Death
8760,	Medical Examiner bhysician and sthe burial-transit	dical Examiner	Due to (or as a consequence of): ATHEROSCLERO Due to (or as a consequence of): ATHEROSCLERO Due to (or as a consequence of): Cause. Enter Underlying Cause. Enter Underlying Chat initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	FIC CARDIOVASCU	LAR DISI	EASE	
P.O. Box 6	The law requires that the death certific the has been signed by the attending prage 2 should be detached for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	ery Day Year
	quires that in signed by	by	Part II. Other significant conditions contributing to death but not resulting in the DIABETES MELLITUS	underlying cause given in Part I.		cco use contribute to t	
Division or Vital Records,		Completed	HYPERTENSION		24a. Was an autopsy perform	prior to co	ppsy findings available mpletion of cause of
Zita	iysician: The lis certificate hadirector, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	_ Other:	h (Check only one)	ce 6 □Other (Specia	5.1
ion oi	Attending Physician: r death. ector: After this certification of the funeral director, it	ation: T	27. Manner of Death 1 № Natural 5 Pending investigation 28a. Date of Injury (Month, Day Year) Injury		28d. Describe how		<u>y</u> ,
Divis	afte Dir Jin	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, s building, etc. (Specify)		City or Town,		,
1	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as s te and place, and due t	stated. the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month,	
•	2		30. Name and address of person who completed cause of death (Item 23a) (Type 913 i Fisca A A A R d	7 1	RY, HO	8-6-	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	CLINTON	NIT	00.13	2

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 15, 2007 4c. County of Death /Medical Otho D. McCarty August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NMS Healthcare Washington
9 Birthplece (State or Foreign Country) Hagerstown
If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 15 M 2□F Months Hours **Director** 216-14-5521 86 January 23,1921 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be rutified at 1 ∑Yes 2 ☐ No Washington Direct Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Fulton Street 21750 Funeral <u>USA</u> or Items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Metalurgist Aircraft Manufacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be f Mental h permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked, any injury or other traumatic evone. Earl N. McCarty Margaret Starliper 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann McCarty/Sister-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Smithsburg Crematory 08/17/2007 Smithsburg, MD 21. Signature II Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List solvione cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiamy o pain y /Medical Due to (or as a consequence of): **Examiner** 144 Per Tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consed ence of) Examine fibrillation physician and s the burial-trans Atrial Due to (or as a consequence of): Completed by Physiclan/Medical the as attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached f Ö 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1□ Yes 2□ Ne 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 ☐ No ၉ 3 DOA this. After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Medical Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0060396 tund 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Open Court Hagerstownmo. 21140 Faria Mushed 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Box 68760 P.O. Division or Vital Records. To the Hospital or Attending within 24 hours after death To the Funeral Director: filled in by the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARIS COASTAL egistrar's Signature 2007

29c, License number D0053410

29d. Date signed (Month, Day, Year)

Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Mess

P.U BOX 1737

29a. Certifier

(Check only one)

29b. Signature and title of pertifier

Medical

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of I			ene	25677
	Physic	an	Decedent's Name (First, Middle, L.)	,				2. Date of Death Month	Day Yea	3. Time of Death
	/Medi	cal	DOROTHY	MUSS		1		Augus	t 2ND 2	207 4:15 AM
	Exami	ner	4a. Facility Name (If not institution, g	ive street and number))	4b. City, Town, o	1.	eath /	4c. County of De	Al .
	Funeral		S. Social Security Number 6.	Sex 7. Ac	ge (In yrs. last birthday)	If Under 1 Year	16 Under 24	Hrs. 8. Date of Birth		
	Director		213-10-5084	1□M 2 X F	96 Yrs.	Months Days		Jan 4,		irthplace (State or Foreign Country) nknown
	pu *		Usual Residence of Decedent 10a. State 10b. County		10- Cit. T-			10011 17		
	Aaryie Faho	ō			10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🔯 No
	28a-	Director	MD Howard 10e. Street and Number		Columbia	10f. Zip Code		10	g. Citizen of What (
	h with		5009 Columbia Ro	ad Apt 204		2104	4		United S	•
	deat deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.			? (Specify Yes or No- uerto Rican, etc.)	14. Race - Am	nerican Indian,
36	within 72 hours after death with the Maryland ane. than "natural", or items 23s or 28s-f show ta Madical Enatifier must be rotified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 21X If Yes, Give	No	1 ☐ Yes 2 № No		dento ricari, etc.)	Black, Wh	nite, etc.
21215-0036	"natural",	q pa	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:					W.	hite
15	in 72 ho n "natur Audical	plet	(Specify only highest g	rade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	working	6b. Kind of Busines	s/Industry
212	d with giene.	Completed	Elementary/Secondary (0-12)	College (1-4or		emaker			Own Home	
pu	be filed tal Hygid d other event, II	Bec	17. Father's Name (First, Middle, Las	t)			18. Mother's	Name (First, Middle, M		
<u>y</u> la		To	Frank Thwaite				Ida	unknown		
Maryland	12 c 7 c 7 c 7 c 7 c 7 c 7 c 7 c 7 c 7 c		19a. Informant's Name/Relationship					Rural Route Number,		
	s 1 and f Health item 27 other tr	l à	John M. Musser/Hi	uspand	20b. Place of Dispo	sition (Name of		pt 204 Colu	mbia, MD Oc. Location - City o	
Baltimore,			Marial 2 ☐ Cremation 3 = 4 ☐ Donation 5 ☐ Other (Spec		cemetery, crei	natory or other plac	. 1	_		
## ## ## ## ## ## ## ## ## ## ## ## ##	그 문문을 .		21. Signaturg of Funeral Service Lice		Druid Ri	Name and Addre	ss of Facility	0-2007	Pikesville	mily FH Inc.
ä	Depa Impo any ir		Herri Olli	- Wathe	101044	112 Old (n idmulo:	arry n. wr a Pike Ell	cott City	MD 21043
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused y one cause on each li	the death. Do not ent	er the mode of dyir	ng, such as car	diac or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ADV	ANCED a consequence of):	DEN	DENT	, A		Onset and Death
	/Medical Examiner		resulting in death)				, , , , , , , , , , , , , , , , , , , ,	-		
36		e	Esquardially list conditions, if any, leading to immediate cause. Enter Underlying	Due to for as	ER7EN5 a consequence of):	100				Monto
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ó	en an erial-tr		resulting in death) Last	c. Due to (or as	a consequence of):					
8760,	The law requires that the death certificate be executed itse has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai		d						
9 ×	entific ding p	Mec	IF FEMALE:	20- 11						
Вох	leath certific attending p	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	Ectopic pregnancy	1		23d. Date of de Month	elivery Day Year
P.O.	the d by the ached	Physician/Me	1 Yes 2 No 9 Unknown	9□ Unknown	inite of death 3E	Other (specify)				
<u>رة</u>	res that the de signed by the a be detached t	by Pl	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ğ	w require been sig should b	ed t						1 ☐ Yes	2 □ No 3 □ P	robably 4 Hinknown
ecc	has be	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available
<u>=</u>	Physician: The la rrthis certificate had aral director, page 2	Con						performe	ed? death?	completion of cause of s
Vita	ician certific ector,	Be	25. Was case referred to medical examiner?	Haspital:		la:		Death Check only one		
o	Phys r this ral dir	5. T	1 Yes 2 No	Hospital: 1 Inpatie			4 Nursin	Home 5 Residen		ecify)
0	Attending Physician: or death. sector: After this certifice by the funeral director,	tlon		(Month, Da)	ry 28b. Time of y Year) Injury	Wor	yat k? Yes 2 ∐No	28d. Describe how	injury occurred	
Division of Vital Records,	Atter	Certification:	3 Suicide 6 Could not to	28e. Place of Inju	ury - At home, farm, stre			28f. Location (Stre	et and Number or F	Rural Route Number,
	tal or	Cert	4 - Hornida	building, etc	c. (Specify)			City or Town,	State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	of my knowledge, death f examination and/or invated.	occurred at the tin restigation, in my o	ne, date and pla pinion, death o	ace, and due to the cau ccurred at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	₩.	29b. Signature and title of certifier			29c. License	e number	290	d. Date signed (Mon	th, Day, Year)
			Spepte	MD		000	05315	~ A	equst.	2ND, 2007
300	-		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type,	Print)		50,	re 110	NO 7-045
Y	S. 45 6 1		Shalewaya 31. Date filed (Month, Day, Year)	CA GUI	UTA 965	OJAN	714C	o KD	COLUN	131 A
9	Sta Registra		30. Name and address of person who Shallow Mar. 31. Date filed (Month, Day, Year) AUG 0 7	2007	we do	barle				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician \mathbf{p}^{M} Robert 6, 2007 Herbert Meyer August 3:55 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5413 Parkvale Terrace Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,)
Feb. 20, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 3 M 2 ☐ F 132-05-0934 87 1920 New Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2X No Directo Maryland Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20853 5413 Parkvale Terrace USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. MXYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify.White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Licensing Officer State Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Meyer Caroline Spitt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Audrey Meyer/Wife 5413 Parkvale Terrace, Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) August 10, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2007 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W., Silver Spring MD 20 pproximate Interval Between Onset and Death WD 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) a. Non-Small Cell Lung Cancer 3 Months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine spital or Attending Physician: The law requires that the death certificate be executed ours after death.

Peral Director: After this certificate has been signed by the attending physician and filled in by the furneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division or Vital Records, 1X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1☐ Yes 2 🐼 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier D38447 August 7, 2007 address of person who completed cause of death (Item 23a) (Type, Print) James Donald Bridges, M.D. 40 W. Gude Drive, #120, Rockville, MD 20850 32. Restrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

AUG 0 8 2007

			1 - For State Registrar	State of Mary		ertificate of			jiene eg. No.	7	258	79
1	Physici	an	Decedent's Name (First, Middle, Last) JOHN	WILLIA	M NELS	SON.		2. Date of Dea Month	Day	Year	3. Time o	
H	/Medic		4a. Facility Name (If not institution, give si		n NED		or Location of Deat	August	7, 20		3:45	Α
34 .	Examin	er *'	Alice Byrd Tawes N		≘		sfield		Somer			
	Funeral Director	1	5. Social Security Number 6. Sex 382-07-9669 1 🗵	M 2 F	yrs, last birthday 36 Yrs.	Months Days			Year) 1920	9. Birthpla County Mary	n/) _	or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or I	ocation				10	d. Inside C	City Limits
	Maryl.	tor	Maryland Somerse	t	Cr	isfield					1 🗌 Yes	2 N 0
	h the	Director	10e. Street and Number			10f, Zip Code		1	0g. Citizen of W	/hat Count	ry?	
	ath wil	ralD	26369 Silver Lane				21817			S.A.		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f ahow amy injury or other traumatic event, the Medical Examinar matalia notified at ances.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	2. Was Decedent Ever Armed Forces? 1 Ves 2 Now If Yes, Give Year or Dates: 147	brld	. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Specify Yes or No- to Rican, etc.)	Blac	e - America k, White, e : Whit	tc.	
Ş	atura Cal E	ted !	15. Decedent's Educ	ation	ar II 16a. Dec	edent's Usual Occu	pation		16b. Kind of Bu	siness/Indi	ustry	
Baltimore, Maryland 21215-0036	d within 7 giene. r then "n	Completed	(Specify only highest grade Elementary/Secondary (0-12) 8	College (1-4or 5+)		e kind of work done DO NOT use retire EYMAN	aduring most or wo	inking	Seaf	ood		
2	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,		•	 1	
<u> </u>	d Meni	ဥ	Gordon Nelson	- Coint	405.14	ling Address (Stree	Elizabe			NKNOW		
<u>a</u>	id 2 sh Ith and 27 is r traun		19a. Informant's Name/Relationship (Type John W. Nelson, Ja			9 Silver				.817	COUB)	
ē,	f Hea item		20a. Method of Disposition	2	0b. Place of Disp	position (Name of ematory or other pla		Date	20c. Location		vn, State	
Ē	Page nent c ant: If ury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ry Cremat	· i	7/07	Salisb	ury,	MD	
Balt	permit. Departr Importu any inji		21. Signature of Function Service License	31		22. Name and Addr Bradshaw 306 W. Ma		uneral Ho Crisfield	ome 1, MD 2	1817		
**************************************		Į.	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the		nter the mode of dy	ing, such as cardia	c or respiratory arr			Approxima Interval Be Onset and	etween
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	nd nd transit	Examiner	Cause (Disease or injury that initiated events									
8760,	cate be executed physicien and the burial-transit	al Ex	resulting in death) Last	Due to (or as a co	nsequence of):							
687	physicate Is the t	edical	d									
Вох	The law requires that the death certificate be executed ete has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of professional 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	☐Ectopic pregnand☐ Other (specify)	су		23d. Dat Mor	e of deliver	y Day	Year
Division of Vital Records, P.O.	uires that t signed by Id be detac		Part II. Other significant conditions con	tributing to death but no	ot resulting in the	underlying cause g	iven in Part I.	23e. Did to	bacco use contr	ribute to the		
Ö	aw requir s been si s should	Completed						24a. Was a	an 24b. V	Vere autop	sy findings	s available
<u> </u>	The la	шo						autop: perfor	meg≨/ c	irior to com ieath? Yes 2		cause or
/ita	cian: ertifica actor,	Bec	25. Was case referred to medical examiner?					ath (Check only or				
_	Attending Physician: r death. ector: After this certification the funeral director.	2	1 ☐ Yes 2 No	ospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpati	BILL 3 DOA		Home 5 ☐ Resid)	
O	ding th. After fune	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ar) Injury	W	ork? ☐Yes 2☐No	200. Describe ii	ow injury occur	30		
Visi	er deal	Certification;	3 Surcide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, s	street, factory, office		28f. Location (S City or Tow		er or Rural	Route Nu	mber,
Ö	itel or A											
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	Medical		ician: To the best of m er: On the basis of exa and manner stated.								(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier			29c. Licer	ise number	- 2	29d. Date signed	(Month, E	Day, Year)	
			· N C	1+9			D 480	98	8/-	7/20	07	•
			30. Name and address of person who con						,			
190			Vijay Karumbunat 31. Date filed (Month, Day, Year)	han, M.D.		all Highw	ay - Cris	sfield, M	D 2181	7		
£2.	Sta Registi		AUG 0 9 2	7 31	w B	South						

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of Hertificate of L			iene _{eg. No.}	17 26880
	Physic /Medi		1. Decedent's Name (First, Middle, La.	060	RODN		A	2. Date of Dear Month AUGUS	T 04,2	3. Time of Death 2007 1:30 A M
	Examir	ner	4a. Facility Name (If not institution, given Hebrew Home of G		hington	4b. City, Town, or Rockv11		th	4c. County of	of Death gomery
	Funeral Director			D	9 (In yrs. last birthday 75 Yrs.	Months Days				9. Birthplace (State or Foreign Country) Russia
	Maryland Ited at	tor	Usual Residence of Decedent 10a. State 10b. County	erv	10c. City, Town or L					10d. Inside City Limits 1X Yes 2 □ No
	with the 3a or 28s	i Direc	10e. Street and Number 6121 Montrose Rd			10f. Zip Code 20852		1	0g. Citizen of W	hat Country?
36	s after death , or Items 23 amhar mus	y Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 14 If Yes, Give		Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race Black	- American Indian, , White, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show ming righty or other traumatic event, the Madical Examinar must be notified at ance.	Completed by Funeral Director	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5	+) (Give	odent's Usual Occupation kind of work done during most of working DO NOT use retired)			Specify: White 16b. Kind of Business/Industry Science	
and 21	should be filed w ind Mental Hygien marked other th umatic event, Illi	To Be Cor	17. Father's Name (First, Middle, Last) Gdaliy Gor	5+	E	Biochemist		me (First, Middle, M La Akimova	Maiden Surname	
Maryland	and 2 shou ealth and M n 27 is mar har traumati	-	19a. Informant's Name/Relationship (7 Kirill Penteshin/	ype, Print) Son=In=la	w 5815	ing Address (Street a	nd Number or Ri	ural Route Number,	City or Town, S	itate, Zip Code) 0852
altimore,	Pages 1 ar nent of Hea ant: If item: ury or othal		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			osition (Name of matory or other place	ns 08/0	Date 2007	Olney,	ity or Town, State
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Se)	2	2. Name and Address		ew Funera	l Home	DC 20012
4	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each lin	the death. Do not en e. BROVA	ter the mode of dying	, such as cardia	or respiratory arre	est,	Approximate Interval Between Onset and Death
	cate be executed by scienary and burial-transit the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ARTERIAL HYPERTENSION Due to (or as a consequence of): C						
	death certiff e attending od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	,
cords, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions or	ntributing to death bu	t not resulting in the u	nderlying cause give	n in Part I.	23e. Did tob	1/	oute to the cause of death?
Ž Ž	The taw ate has b page 2 s	Completed						24a. Was ar autopsy perform 1 Yes 2	/ - Dri	ere autopsy findings available or to completion of cause of ath? Yes 2 No
Vision of Vital	Phys this aldi	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Many r of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatien 28a. Date of Injury (Month, Day	28b. Time of	ot 3 DOA Other	4 Volumsing H	ome 5 Tesider 28d. Describe hor	nce 6 Other	
DIVIS	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Płace of Injur building, etc.	ry - At home, farm, str (Specify)	eet, factory, office		28f. Location (Str. City or Town,		or Rural Route Number,
	he Hospit in 24 hour he Funera pletely fille	edical	29a. Certifier (Check only one) 1 Certifying Phy	sician: To the best of ner: On the basis of and manner stat	examination and/or in	n occurred at the time vestigation, in my opi	, date and place nion, death occu	, and due to the ca rred at the time, da	use(s) and manr te and place, an	ner as stated. d due to the cause(s)
	O C miles	Σ	29b. Signature and title of certifier	Loll	ren	29c. License	5			Month, Day, Year) 7 04, 2007
~	(4)		30. Name and address of person who of BARBACAKACA	mpleted cause of de	ath (Norm 23a) (Type.	OWTROSE	ERD, &	DOKVIL	16,4	104,2007 1D20852
	Star Registra	- 1	AUG 0 7 2007	32. Registrar	's Signature					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav . Month Year Physician 17:00/PM 7 LYVESTA PRICE 28 2007 JEAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TAKOMA PARK MARYLAND MONTGOMERY WASHINGTON ADVENTIST If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 9 / 2 0 / 2 0 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 223-20-8004 Yrs. VIRGINIA 86 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location show aţ PRINCE GEORGE 1 X Yes 2 No Director HYATTSVILLE MARYLAND MARYLAND 28a-f with the 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ò be 1518 CHILLUM ROAD APT.0003 20782 U.S.A. death v items 23a **Examiner must** Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2¾ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ,0 Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 X Divorced 'natural", Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) CONGRESS P LIBRARIAN . Pages 1 and 2 should be filed wi tment of Health and Mental Hyglen tant: If item 27 is marked other th Jury or other traumatic event, the 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LELIA JOHNSON BALL JOSERH BALL 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 7 8 2 permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 is any Injury or other trau WAYNE PRICE (SON) 1518 CHILLUM ROAD APT 0003 HYATTSVILLE MD. Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐Removal from State BALL FAMILY CEMTERY 8/4/07 LANCASTER VA. 22503 4 □ Donation 5 □ Other (Specify) 21. Si nat e of Funeral Service License 22. Name and Address of Facility BERRY O. WADDY 6784 MARYBALL ROAD LANCASTER VA. 22503 23a. Part1. Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on ear in line. Approximate Interval Between Onset and Death Immediate Cause (Fnal disease or condition resulting in death) Cona **Physician** /Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Examine be executed that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 ☐ Unknown ģ Part II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform certificate Division or Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manher of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Acident death Director: To use, within 24 hours after ...

To the Funeral Director 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🖔 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 30. Name and address use of death (Item 23a) (Type, Print) , Day, Year: State 2

Registrar

AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year James 0. Posey, Sr. 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat ATA If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Min. 8. Date of Birth Min. (Month, Day, Year) January 3,1933 Social Security Number 1 M 2 ☐ F Maryland 216-30-4554 74 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Charles Marbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5530 Bicknell Road 20658 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Tech Federal Govt. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas W. Posey Susie Bowie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Posey/Wife P.O. Box 336, Marbury, MD 20658 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gar. 8/8/07 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, MD shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PREUMONIA days disease or condition resulting in death) Due to (or as a consequence of): cerebral vascular accident Year S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner

Important: If it any injury or o

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

event, the Medical

marked other

Director

Funeral

Completed by

Be

2

Examiner

Be Completed by Physician/Medical

Certification: To

Medical

MD

death with the Maryland

Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene.

physician and s the burial-tran as attending | been signed by the should be detached page 2 s has certificate

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		topic pregnancy her <i>(specify)</i>	2	3d. Date of delivery Month Day Year
	contributing to death but not resulting in the under Heart Failure, Demen		23e. Did tobacco u	se contribute to the cause of death?
	llation, Colon Cancer, us Lyndrome	, Proxtate Carer	24a. Was an autopsy performed? 1□ Yes 2 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of Dea	ath (Check only one)	
examiner? 1 ☐ Yes 2 ◯ No	Hospital: 1		lome 5 ☐ Residence €	i □Other (Specify)
27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred /
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		factory, office	28f. Location (Street and City or Town, State)	f Number or Rural Route Number,
	Physician: To the best of my knowledge, death or aminer: On the basis of examination and/or investigation.			

the Hospital or Attending Physician:

Director:

e Funeral D letely filled i 24 hours

the

10

State Registrar

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) August 4th, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

avinder K. Sindhwani 31. Date filed (Month, Day, Year)

AUG 08

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 4-25PM Theresa Bernardine Perseghin 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Lorien Nursing&Rehab Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday, if Under Hours 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 1 ☐ M 2 🗙 F Maryland 219-01-9256 85 March 24,1922 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Ellicott City 1 ☐ Yes 2X No Howard 10f. Zip Code 10e. Street and Number 10g Citizen of What Country?

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. "natural", or items 23a or 28a-f show edical Examiner must be notified at Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner

attending physician and for use as the burial-trar After this certificate has been signed by the funeral director, page 2 should be detached

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

ķ	Md. Howard	3	1	Ellicott Ci	ty			1 □Yes 2X No		
je	10e. Street and Number	<u> </u>		10f. Zip Code			10g. Citizen of Wh	at Country?		
al D	4701 Bounty Ct.			210	043		US	SA		
ne	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S.	13. Was Decedent of H		ecify Yes or No-	14. Race -	American Indian, White, etc.		
Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:	7 110411, 010.7		White		
ted	15. Decedent's Ed (Specify only highest grad	ucation		i. Decedent's Usual Occup (Give kind of work done		I	16b. Kind of Busin	ness/Industry		
nple	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retired	d) "	ung				
Con	12yrs			Homemakei			Own H			
To Be	17. Father's Name (First, Middle, Last) Anthony Citu	ık					e, Maiden Surname) Skrucha			
	19a. Informant's Name/Relationship (7) Gerard A. Perseghi			Mailing Address (Street 3 Wiggleswo	and Number or Ru	ral Route Numbe	er, City or Town, St			
- 9	20a. Method of Disposition	20	b. Place of	Disposition (Name of y, crematory or other place	3	Date	20c. Location - Ci			
	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		nislaus Cen	1	/2007	Dundalk	Ма		
	21. Signature of Funeral Service Licersee 22. Name and Address of Facilit Harry H. Witzke's Fami									
	MOO845 4112 Old Columbia Pike Ellicott City,									
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the done cause on each line.	eath. Do n	ot enter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between		
	Immediate Cause (Final disease or condition resulting in death)	a. CEREB	rov	ASCULA	n A	ENY	Onset and Death			
	Due to (or as a consequence of): h PERTENSION									
iner										
Exam	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a cons	sequence o	f):						
ical		.d								
Med	IF FEMALE:	23c. If yes, outcome pf pre								
Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	of delivery n Day Year								
/ Ph	Part II. Other significant conditions co	ontributing to death but not	resulting in	the underlying cause giv	en in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?		
ed b						1□Y	es 2 No 3	Probably 4 Unknown		
Somple						24a. Was a autop perfor 1∐ Yes	sy prio	ere autopsy findings available or to completion of cause of ath? Yes 2 No		
Be (25. Was case referred to medical examiner?				26. Place of Deat		ne)			
인	1 Yes 2 UNe	Hospital: 1 ☐ Inpatient 2	2 ☐ ER/Out	patient 3□ DOA Oth	er: Wursing Ho	ome 5 Resid	ence 6 □Other	(Specify)		
	27. Manner of Death 1- Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Ti	jury Wor	yat k? Yes 2 □ No	28d. Describe h	ow injury occurred			
Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - A building, etc. (Spe	t home, far ecify)	m, street, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,		
dical (29a. Certifier (Check only one) Check only one)	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, nination and	death occurred at the till for investigation, in my d	death occurred at the time, date and place, and due to the cause(s) and manner as stated. or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)					
Me	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date signed (i	Month, Day, Year)		
	> The	MD		DOC	23120)	AVG U5	7 6 cm 2007		
	30. Name and address of person who c	completed cause of death (I			hap	nd su	ute 110	Columbia		

State Registrar

31. Date filed (Monta

MO 21045

			1 - For State Registrar	State of M	laryland	•	rtment of F		nd Mei		ene	07	2588;	
		9	1. Decedent's Name (First, Middle, Las	st)					2.	Date of Death			3. Time of Death	
	Physici		Daniel Joseph	Pawlak					١,	Month August	Day 5 200	Year 7	5:20 ^{a M}	
3,11	/Medio		4a. Facility Name (If not institution, give		·)		4b. City, Town, o	r Location of I		rugust	4c. County		3.20	
7	Examin										Mont	~~mai	MT *	
100	Funeral	3 11	Montgomery Gener 5. Social Security Number 6. S		ge (In yrs. la	st birthday)	Olney If Under 1 Year	If Under 24		Date of Birth		gomes 9. Birthp	place (State or Foreign ntry)	
в	Director		327-30-0690	™ M 2□F	70	Yrs.	Months Days	Hours	Min.	(Month, Day, 1	1937		llinois	
			Usual Residence of Decedent							,				
	ylan ylan at		10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits	
	a-f sl	홙	Maryland Mor	tgomery		Silv	er Sprin	g					1 ☐ Yes 2 ☐ No	
	h the	Director	10e. Street and Number			-	10f. Zip Code			10	g. Citizen of V	Vhat Cour	ntry?	
	h wit	a D	15107 Interlacher	Drive, #	‡520			20906	5		USA			
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show deal Examiner must be notified at	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S	3. 13.	Vas Decedent of H f Yes, specify Cuba	lispanic Origin	in? (Specify	y Yes or No-		e - Americ		
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2	within iene. than " he Mec	ğ	Elementary/Secondary (0-12)	College (1-4or	5+)	`life. L	OO NOT use retired	d) "		ľ				
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nd	tal H d oth	Be	17. Father's Name (First, Middle, Last)	1				18. Mother's	's Name <i>(F</i>	irst, Middle, M	aiden Surnan	ne)		
<u>yla</u>	ould be f Mental I narked or	ို	Chester D. Pawlak							e M. Sw				
Maryland	2 sho		19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street	and Number	or Rural F	loute Number,	City or Town,	State, Zip	CodeMD 20906	
	and ealth n 27		Elizabeth Marie	Pawlak/Wi				7 Inte			ve, #5	20, 8	Silver Spri	
<u>S</u>	of Her	li 3	20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Damoval from State	ca	ace of Dispo emetery, cren	sition (Name of natory or other plac	ce)	Augus		0c. Location -	City or To	own, State	
Ĕ	Pages nent of f ant: If ite		4 □ Donation 5 □ Other (Specif		[*] Gate	of He	eaven Cem	etery	_	·	ver Sn	ring	. Maryland	
altimore,	+ + + + -		21. Signatur of Juneral Service Licer	21. Signatur of Juneral Service Licensee 22. Name and Address of Facilities Funeral Home Inc.										
m	permi Depar Impor any ir	40 0	(undrew	Lole	2	i de							g, MD 20901	
4			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	ed the death.							1	Approximate Interval Between	
	Physician	S 1	Immediate Cause (Final	One cause on each	occ la	calic	1000						Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to (or a	s a conseque	ence of):	Cardie	vascu	clar	Other	76	_	years	
	Examiner			240 10 (0) 4	o a concequ	01,00 01,								
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	nsit	듩	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
	cate be executed physician and the burial-transit	Examiner	resulting in death) Last	Due to (or a	s a conseque	ence of):								
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687	ficate phys s the	edical		• O										
	w requires that the death certifit been signed by the attending t should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcom	e pf pregnan	ncv					23d Da	te of delive	en/	
Box	eath atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	death 3□	Ectopic pregnancy Other (specify)	У				nth	Day Year	
Ö	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	at time of de	atii o_	gourer (openiny) <u></u>							
P.0	that t	P	Part II. Other significant conditions of	ontributing to death	but not resul	Iting in the ur	nderlying cause giv	en in Part I.		23e. Did toba	acco use cont	ribute to t	he cause of death?	
Records,	sign d be	l by								1 ☐ Yes	3 2 □ No	3 ☐ Prob	pably 4 Unknown	
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	: The	Completed								perfor ro 1∐ Yes 2	No	death? 1 □ Yes	2 □ No	
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	ng P		27. Manner of Death Natural 5 ☐ Pending	28a. Date of In (Month, D	jury (:	28b. Time of Injury	28c. Injui Wor	y at k?	280	d. Describe how	v injury occur	red		
<u>Si</u>	Attending r death. ector: After by the funer	atic	2 ☐ Accident investigation					Yes 2 □ No	lo					
ž	if or Att after de Direct	ţţ.	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of II	njury - At horetc. (Specify)	me, farm, str)	eet, factory, office		28f	Location (Street). City or Town,	et and Numb State)	er or Rum	al Route Number,	
	tat or rs after al Dir	Certification:												
	lospi hou uner uner	cal	29a. Certifier 1 Certifying Ph	ysician: To the bes	t of my know	vledge, death	occurred at the ti	me, date and	f place, and	d due to the ca	use(s) and ma	anner as s	stated.	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely illied in by the funeral director, page 2	Medical	one)	and manner s										
	Vith To t	Σ	29b. Signature and title of certifier				29c. Licens	e number		29	d. Date signe	d (Month,	Day, Year)	
			Mulleul	Alsen 11	10		D00	18429	7	F	fugust	5 3	2007	
(500		30. Name and address of person who	completed cause of			Print)				J			
(3)	, 🐷		Phyllis Nicholson,	MB 18	101	Prince	Print) Phillip	Driv	le	Olne	1. Ma	rylan	d 20832	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Pajis	trar's Signati	ure					, ,	1		
	Regist	rar	AUG 0 7	2007	ر مس	B. 1	back,							

Amended Item 18 per F.D. 08/07/2007 Carroll County, wil Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 5, 2007 **Physician** 12:55 p M Victoria Gardner Plank /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Hospice Dove House | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Apr 9/1948 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Pennsylvania 1 □ M 2 😿 F 59 Director 205-38-5358 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at New Windsor Carroll 1 ☐ Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? p o USA 21776 1530 Old New Windsor Road ns 23a c must b Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

int: If item 27 is marked other than "natural", or items 23, mir: If item 27 is marked other than "natural", or items 23, my or other traumatic event, the Medical Examiner must vny or other traumatic event, the Medical Examiner must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname)
Ferne Arelia Sponsellor 17. Father's Name (First, Middle, Last) Be Donald Warren Gardner ၉ Ferne Arelia Sponseller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Toyon State, Zin Gode 21776 Robert H. Plank, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or once. St, Luke's (Winter's) 8/9/2007 New Windsor, MD 4 ☐ Donation 5 ☐ Other (Specify) M01191 22. Name and Address of Facility 21, Signature of Funeral Service Licensee Myers-Durboraw Funeral Home ust. 91 Willis Street, Westminster, MD 21157 23a. Part1 Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? 2 1 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Certification: To 27. Man or of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier WJL 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 4 bruter 31. Date filed (Month, Day, 32. Registrar's Signature Year State Registrar AUG 0 7 2007

*			1 - For Amend Item 24		,g871,0	9/18/0 Cer	tificate of	Death		Reg. No.		2.000
	Di		Decedent's Name (First, Middle, Last,						2. Date of De. Month		V	3. Time of Death
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4	Examir	ier	Tall I domly reality (it not institution, give	stroot and mamber,			4b. Oily, 10411, 01	Location of Death		40. 000111	y or Death	
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	Funeral		5. Social Security Number 6. Sex		(In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country)			lace (State or Foreign try)
	Director		217-10-3530]M 2X)F	91	Yrs.	Months Days	Hours Will.	2-20-19		1	vland
£	7		Usual Residence of Decedent					1		710	I Hary	y Land
	land bw		10a. State 10b. County		10c. City, T	own or Lo	cation				10	0d. Inside City Limits
	dary	5	100									1 ☐ Yes 2 ☑ No
	1 of 1	S	MD Wicomico		Sal	isbu	*					
	er 2	5	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	try?
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-1 show ent, The Modical Examiner must be notified at	Funeral Director	118 Lakeview Drive				2180	4		US.	Δ	
	ms ms	Jer	11. Marital Status	12. Was Decedent E	ver in U.S.	13. V			ecify Yes or No		ce - Americ	an Indian.
	Ite	Ė	1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 🔀 N	0	1	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Bla	ack, White,	
36	s al	by	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	•	1	☐ Yes 2X No	Specify:		Speci	か: Whit	·e
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O	filed Hygi other		17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle,			
Maryland	od be	Be	Wade H.	Rri	itting	hom						
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ā	s 1 and 2 should be tiled within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Examinal must be notified.	0	19a. Informant's Name/Relationship (Ty			19b. Mailin	g Address (Street a	and Number or Run	al Route Numbe	or, City or Town	, State, Zip	Code)
	1 and 2 Health tem 27 I		Gorman Brittingham	- cousin		4820	Powell S	chool Roa	ad, Pars	onsbur	MD	21849
ē	te de de		20a. Method of Disposition		20b. Place	e of Dispos	sition (Name of natory or other place	-	Date	20c. Location		
2	age nto r: #		1 ⊠ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	1	•		1				
Ξ	permit. Pages 1 and Department of Heall Important: If item 2 any injury or other Once.		4 □ Donation 5 □ Other (Specify)		Pars		Cemetery	8-9-	-2007	Salisbu	iry, M	faryland
Baltimore,	permil Depar Impor any ir		21. Signature of Funeral Service License	a 1	/	22	Name and Addres	is of Facility Bou	inds Fun	eral Ho	ome	
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	V		23a. Part. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused	the death. [Do not ente	er the mode of dying	, such as cardiac	or respiratory ar	rest.	ar y ran	Approximate
			shock, or heart failure. List ently or Immediate Cause (Final	e cause on each line	γ						-	Interval Between Onset and Death
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	/Medical		resulting in death)	Due to (or as a	consequen	ce of):						200,000
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XO	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burral-transit	M	IF FEMALE:	3c. If yes, outcome o	f pregnancy	,				2010	WANT TO THE	
m	res that the death cer igned by the attendin be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2	Petal dea	ath 3 🗌	Ectopic pregnancy				ate of deliver	ry Day Year
	pe de	Sic	1 ☐ Yes 2 No	4☐Pregnant at t 9☐Unknown	ime of death	າ 5∐	Other (specify)					- ay
о. О	by t	, b	9 Unknown \									
	s this	by F	Part II. Other significant conditions con	tributing to death but	t not resultin	g in the un	derlying cause give	n in Part I.	23e. Did to	bacco use con	tribute to the	e cause of death?
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_	ding h. After funer	5	27. Mann of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28t	b. Time of Injury	28c. Injury Work	at ?	28d. Describe h	ow injury occur	rred	
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Division of	Dire	ert	4 Homicide determined	building, etc.	(Specify)		,,		City or Tow	n, State)		
	urs urs erel											
	e Hospitel or Attending Physicien: 24 hours after death. # Funerel Director: After this certific etely filled in by the funeral director.	Medical	29a. Certifier Certifying Phys (Check only 2 Medical Examin	ician: To the best of	my knowled	dge, death	occurred at the tim	e, date and place,	and due to the d	ause(s) and m	anner as sta	ited.
	he h	De l	one)	and manner state	ed.	arror irre	estigation, in my op	inton, death occurr	ed at the time, t	iate and place,	and due to	the cause(s)
	To the Hospitel within 24 hours a To the Funeral I completely filled	Σ	29b. Signature sid title of certifier	1 1 1	~		29c, License	number		9d. Date signe	d (Month, C	Day, Year)
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1	TIN		30 Name and address of person who con	mpleted cause of de	ath (Item 2	HILTyps F	rint) 2 52	306 5	11. h	11.300	7 91	21
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			for State Registrar	State of Mi	ai yiaiiu /		rtificate of		Mental Hy	Reg. N		26887
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	h the or 28a	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cou	intry?
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336	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or Items 23a or 28a-f show I matic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub 1 ☐ Yes 25 No	lispanic Origin? (8 an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.))-	14. Race - Amer Black, White Specify: Whi	, etc.
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	nd 2 alth a 27 is r trai		Karen A. Wilson				Oxley Fo					
ē,	es 1 a of Hea fitem ir othe		20a. Method of Disposition	·			osition (Name of matory or other place		Date Date		Location - City or T	
Ĕ	Pages nent of int: If Its iry or o		1 ☐ Burial 2X☐Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				tan Crema		3-07	Ale	xandria.	Virginia
Baltimore,	permit. Pages Department of Important: If It any Injury or o	li	21. Signature of Funeral Service Lic	ensee	0.0	F2	Name and Addre	scoffilins				
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O. Box	at the death cert I by the attending stached for use a	Physician//	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deat		□Ectopic pregnanc; □ Other (specify) _	′			23d. Date of delive Month	very Day Year
S, J	requires that the een signed by th nould be detache	by PI	Part II. Other significant conditions	contributing to death be	ut not resulting	in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ğ	w require been sig should b								10	Yes	2□No 3□Pro	bably 4 Unknown
Hecord	sician: The law re certificate has be- rector, page 2 sho	Completed		· · · · · · · · · · · · · · · · · · ·					24a. Was auto perfo 1□ Yes		prior to co death?	opsy findings available ompletion of cause of
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5	Physician: this certific	2	1 Yes 2 √ No		nt 2 ER/O			4 Li Nursing F			6 ☐Other (Spec	ify)
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2)	a2	-	30. Name and address of person wh				Print)	•				
الة			Ramesh Sabapath			ck	River Nec	k Road,	Baltimo	re,	MD 21221	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0	3 2007	ar's Signature	* ,	Coule					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** AM RAFEL 8 1135 nogman 04 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mentgemery

9. Birthptage (State or Foreign Suburban mo Bethesda Hospital If Under 1 Year | If Under 24 Hrs. | 8. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days Year) 1**™**M 2□ F New York 098-03-7518 8 Yrs. Director 08/23 1919 Usual Residence of Decedent 10c. City, Town or Location
Chevy Chase 10b. County Montgomery 10d. Inside City Limits 28a-f shov d other than "natural", or items 23a or 28a-f shovevent, the Medical Exa<u>miner must be notified at</u> MD 1 □Yes 2X No Director 10f. Zip Code 20815 10e. Street and Number 10g. Citizen of What Country? USA 3400 Coquelin Terrace permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar," or items 23s any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must gonee. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐ Yes 2**反** No f Yes, Give ′ear or Dates; 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ₩ No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N.A.S.A. Aeronautical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida Altman Samuel Rafel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3400 Coquelin Terrace Chevy Chase, Md 20815 19a. Informant's Name/Relationship (Type. Print) Vicki Powers Rafel/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Renfoval from State Chesapeake Crem. 8/06/07 Beltsville, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature neral Service Live see PHILIP D. RINALDI FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 9241 columbia Blvd.Silver Spring,Md20910 Immediate Cause (Final disease or condition resulting in death) **Physician** Myomhotic Thrombourtonenic /Medical Due to (or as a consequence of) Examiner renal rai Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine NINEMONIA physician ar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy this certificate 2 No To the Hospital or Attending Physician: whin 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No 1

☐ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive Rockville, Md 20850 MD Atul Rohatgi

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 07

NORMON

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 200 Margaret Rennie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Prince George's Doctor's Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Scotland 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Mar. 23, 5. Social Security Number 6. Sex **Funeral** Year) Months Hours Days 1 □ M 2 🕅 E Yrs. Director 215-52-7688 68 1939 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1√ Yes 2 No Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20715 Scotland 2711 Kenhill Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XXNo Specify: White 2 3X Widowed 4 □ Divorced Completed Baltimore, Maryland 21215-6 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Unknown Unknown 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr once, Ray A. Rennie / Son 2711 Kenhill Drive Bowie, MD. 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 08/07/2007 Alexandria, VA. 21. Signature of Funcial Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Highway 20715 Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed ending physician and use as the burial-trai Due to (or as a consequence of) P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mod 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) ned by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 1 Yes

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Completed by Be

Certification: To s after death.

I Director: After this of in by the funeral d

within 24 hours aft To the Funeral Di

To the Hospital or Attending Physician:

State Registrar DHMH 17 Rev 1/2001

25. Was case referred to medical examiner? 27. Manner of Death 29a, Certifier Medical

1 ☐ Yes

2 Accident

3 ☐ Suicide

4 ☐ Homicide

2 H

5 Pending investigation

Year)

Could not be

determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

29c. License number MOD 40611

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

LANHAM, MD JOZOT

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

autopsy perform

28d. Describe how injury occurred

2 No 3 Probably 4 Unknown

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 GODD LUCK KUAD

Hospital:

AW, MD 32. Registrar's Signature

1 Inpatient

(Month, Day

28a. Date of Injury

Amve 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 0rva1 Rhodes 08 14 07 1715 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death WMHS Braddock Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 27, 1928 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country). **1**□M 2□F W/V 234-38-8260 79 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits MD Allegany Cumberland y ☐Yes 2☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 522 Sheridan Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. X Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify: Specify: white **¾**☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Kelly-Springfield supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Zelda M. Rhodes William D. Rhodes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15207 Brandowine Dr. Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) Lee Rhodes son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/17/2007 Sunset Memorial Park MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 7. Enler the disease, or complication. Hit is caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Imme te Cause (Final LISRANDRY APTERY 11132455 YRC

Physician /Medical Examiner

Physician

/Medical

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Funeral

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r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

or. After this certificate has been signed by the attending physician and he funeral director, page 2 should be detached for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	resulting in death)	Due to (or as a consequence of):		710-7100			(.03
	- 1	Due to (or as a consequence of):					
miner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):					
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Complete					24a. Was an autopsy performed? 1□ Yes 2☑ No	24b. Were autopsy prior to comple death?	
Be (25. Was case referred to medical examiner?			26. Place of Death	(Check only one)		
70 E	1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpa	tient 3 DOA	Other: 4 Nursing Hon	ne 5 Residence	6 ☐Other (Specify)	
ation:	27. Man or of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		e of 280 ry M	c. Injury at 2 Work? 1 ☐ Yes 2 ☐ No	8d. Describe how injur	y occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, o	office 2	8f. Location (Street an City or Town, State	d Number or Rural Ro)	oute Number,
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ž	29b. Signature and title of certifier	0 1	29c. l	icense number	29d. Dat	te signed (Month, Day	, Year)

10

State Registrar M.D

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year) 2 1

Barrera

D-14865

500 Memoria 1 Avenue, Cumberland MD, 21502

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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amit Suri, MD 7503 Surratts Road Clinton, Maryland 20735 State 31. Date filed (Month, Day, Year) 32. Resistrar's Signature	<u>S</u>	ttenc death stor: , the	icat	3 Suicide 6 Could n	ot be	of injuny - At he	ome farm et		res 2 INO	29f Location	(Stroot and Num	bor or Pu	ral Pouto Number	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amit Suri, MD 7503 Surratts Road Clinton, Maryland 20735 State 31. Date filed (Month, Day, Year) 32. Resistrar's Signature	<u>></u>	after a	ertif	4 ☐ Homicide determi	ned 20e. Flac	ding, etc. (Specif	y)	eet, factory, office				ber or na	rai noute Number,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amit Suri, MD 7503 Surratts Road Clinton, Maryland 20735 State 31. Date filed (Month, Day, Year) 32. Reference 33. Date filed (Month, Day, Year) 32. Reference 33. Refe		spita nours neral		29a. Certifier 1 Certifying	g Physician: To th	ne best of my kno	wledge, deat	h occurred at the tir	me, date and place	e, and due to the	e cause(s) and n	nanner as	stated.	11
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amit Suri, MD 7503 Surratts Road Clinton, Maryland 20735 State 31. Date filed (Month, Day, Year) 32. Reference 33. Date filed (Month, Day, Year) 32. Reference 33. Refe		n 24 h	edic				tion and/or in	vestigation, in my o	ppinion, death occu	rred at the time	e, date and place	, and due	to the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amit Suri, MD 7503 Surratts Road Clinton, Maryland 20735 State 31. Date filed (Month, Day, Year) 32. Reference Signature		To ti withii To ti comi	ž	29b. Signature and title of certifier	1	/		29c. Licens	e number		29d. Date sign	ed (Month	n, Day, Year)	
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State 31. Date filed (Month, Day, Year) 32. Revistrar's Signature	(1 12				•				00707	-		<u> </u>	
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		-	= State Registrar		Ce	rtificate of D	eath	lental Hyg	Reg. No.	2.1002
E			Decedent's Name (First, Middle, Last	st)				2. Date of Dea	nth	3. Time of Death
	hysicia /Medic		Galil	G.	Safa	adi		Aug.	06, 2007	5:08 PM
	xamin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or I			4c. County of Dea	
			Union Hospital		ro loot hirthday	Elkto	on If Under 24 Hrs.	8. Date of Birth	Cec	
	neral ector		221-02-3/1/	ex XXM 2□F 7. Age (In y	rs. last birthday) Yrs.	Months Days	Hours Min.	Month, Day	2 1022	rthplace (State or Foreign Country)
land	A +1	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
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h the	noti	irec	10e. Street and Number	34.5325		10f. Zip Code			10g. Citizen of What C	Country?
th wil	ust b		155 Willamette	e Drive		197			USA	
er des	rems ner m	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe i, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
ILLISTONOSO filed within 72 hours after death with the Maryland Hygiene. Hygiene.	item z/r is marked other than natural, or tems z.as or zea-i show other traumatic event, the Medical Examiner must be notified at	by F	1 ☐ Never Married	1 Yes 2 X No If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:		Specify: A	rbric
2 hou	ical E		15. Decedent's Ed	ducation	16a. Dece	edent's Usual Occupa	tion	ina	16b. Kind of Busines	s/Industry
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2 should be and Mental is marked of	matic	은	Gamil Safadi 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street a			er, City or Town, State,	Zip Code)
t and 2 sho Health and	r trau		Sami Safadi_(s						ear, DE]	
es 1 a of Hei	or other	Ì	20a. Method of Disposition	20b		osition (Name of ematory or other place		Date	20c. Location - City of	
rmit. Pages partment of I	ury o		1 X Bunal 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removar from State		ints Cem.	1	10/07	Wilmingt	on, DE
permit. Page Department of	any Inj once		21. Signature of Pureral Service Licer	CC0442	l E	2. Name and Address Beeson Fu	ineral H	Home of	f Newark	DE 19702
*			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	eath. Do not en	iter the mode of dying	, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
Physi	ician		Immediate Cause (Final disease or condition	Alhen	usclem	tie Heer	+ diseas	<u>se</u>		Conset and Death
/Med	dical		resulting in death)	Due to (or as a cons	sequence of):	tic Hear Iellitis				unknown
LAUII	4	7	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	VIII J	recurs				MAJavn
nted	sit	in	cause (Pieses er injury	240 10 (01 40 4 00110	00 4 00 1100 01/1					
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ath certificate be extraording physician	ittending prysician and for use as the burial-tran	edical	that initiated events	23c. If yes, outcome pf pre-	egnancy Fetal death 3 [□Ectopic pregnancy			23d. Date of d Month	elivery Day Year
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07-06182

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Albert Siter		State I- For State Registrar	e of Maryland		rtment of <i>tificate of</i>			Mental		eg. No.	17 2383
Physiciai Medical Examin	n/	1. Decedent's Name (First, Middle,La ALBERT RICH	•	ER					2. Date of Dea Month August 11	Day Year	3. Time of Death 1332 hrs
, .		4a. Facility Name (if not institution, g 13350 Clark Road	ve street and number)		4	b City, T	own, or Lo	cation of De		4c. County of Deat	h
Funeral Director		171-26-2529	Sex 7. Age	e (In yrs. Ia	est birthday) Yrs.	If Unde	r 1 Year B Days		Hrs. 8. Date of Bi	Forei	rthplace (State or gn PA ountry)
		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	on	_				10d. Inside City Limits
*	اة	MD Kent		WOI	rton						1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at one.	Director	10e. Street and Number 13350 Clark R	₽d.			10f. Zip	^{Code} 678			U.S.A.	untry?
after death with the Maryland "al", or items 23a or 28a-f she iner must be notified at one.	Funeral								(Specify Yes or No erto Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
after de	by Fu									Specify: Wh	
2 hour "natu	eted	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade com College (1-4 or t		16a. Decedent during mo			n (Give kind OO NOT use		16b. Kind of Business	/Industry
within within siene her than her than than than than than than than than	Completed	12 17. Father's Name (First, Middle, Las	4)		Hort:	icul			ame (First, Middle,		e Florist
21 be fi nntal]	e e	Bartlett E. S:	iter				F	Ielen	Wheigh	tman	
MD 2. d 2 should th and M. n 27 is m;	٥	19a. Informant's Name/Relationship Deborah Rayer	Type, Print) (daught	er)						mber, City or Town, Stat $1 { t ey} \ { t Park}$,	e, Zip Code) PA. 19078
_ 0 0 5 2	1	20a. Method of Disposition 1 Burial 2 X Cremation 3	Removal from Sta	te C	Place of Disposi rematory or oth	er place)		·	Date	20c. Location - City o	
or an P E	r	4 Donation 5 Other Speed	The green	Ke	ent Cre				/14/07	Smyrna,	
21 32 2 1 3 2 3 3	-	MC		0051	0 Ga 118	lena We	Fur st C	erál ross	Home o St. Ga	f Stephen lena, MD.	L Schaech 21635
Physician /Medical	1	23a Part I. Enjer the disease, or com failure. List only one cause on a Immediate Cause (Final disease				ie mode c	r ayırıg, sı	ion as cardia	ic or respiratory an	rest, snock, or neart	Approximate Interval Between Onset and Death
Examiner	1	or condition resulting in death)	Due to (or as a conse					19. T		18	
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):						
re executed or and rial - transit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
60, e be execut	edical	UNPENDED	AMENDED Ite	MENDED Item/4b,28f,perME,C870,8/21/07,WS						<u> </u>	
- 0 S-1 .	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon	ne of pregr	nancy 2 Fet	ancy 23d. Date of delivery					
Box (e death ce the attence of for use	Physician/M	1 Yes 2 No 9 Unknow	4 Pregnant at g Unknown	time of dea	ath 5 Oth	ner (Spec	cify)			1	
P.O.		Part II. Other significant conditions	contributing to death	but not re	esulting in the u	nderlying	cause giv	en in Part I.		obacco use contribute to s 2 ✓ No 3 Pro	
ords, P.C. w requires that us been signed I should be deta	Completed by								24a. Was	an 24b. Were a	autopsy findings available completion of cause of
Reco									perfo	ormed? death?	_
of Vital Records, ag Physician: The law required the three that the thre	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2	ER/Outpatient			hor	eck only one)	Residence 6 V Other	er: Scene
┍╶╡╶∼⋷┃	- 1	27. Manner of Death	28a. Date of Inju (Month, Day Y Aug 11, 2007	ry ear)	28b. Time of Ir	njury 2	t8c. Injury		28d. Describe Subject sho	how injury occurred of self	
~ = 8 5 ×	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Num									tural Route Number, City	
2 2	- 1	4 Homicide determin	Homicide determined (Specify) Farm/Ranch 13350 Clark Road, Betterton, MD								
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: Completely filled in 5 the	edica	one) 2 Medical Examine								and place, and due to t	
	≥	29b. Signature and title of certifier	MAX			29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 12, 2007					
	-	30. Name and address of person who	•	,	,				ID 04557		
∫© Sta	te	7	Assistant Medical			enn Str	eet, Ba	Itimore, N	1D 21201		
Registr	ar	31. Date filed (Month, Day, Year) AUG 2 1 2	007 States	لگر ب	Spa	w					

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Lucille Louise Sanchez 5:20 P. 2007 /Medical August 13. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Solomons Nursing Center Solomons Calvert If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Director 212-16-2935 86 10/29/1920 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits ms 23a or 28a-f shc r must be notified a MD Calvert Lusby 1 ∐Yes 21∑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 158 Leason Cove Drive 20657 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 'natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic ever John M. Burgess Mary Hornback 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2.
...ent of Health an
.nt: If item 27 is no voroth 600 Rockford Road, Silver Spring, Maryland 20902 Paul Christen Sanchez (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once, Metropolitan Crematory 8/14/07 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P. 0. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LUNG CANCER WITH 475 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter bridering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HTW, COPD, ATRIAL 1 Yes 2 No 3 Probably 4 Unknown FIBRILLATION, ADRTIC STENOSIS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an END STAGE CHF cate has by autoosv performed? 1□ Yes 2 No To the Hospital or Attending Physician: ours after death.

Neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ၉ 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 172 Natural 28h. Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 147 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
21 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D36969 August 14, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Scaria Mathew, MD 11910 H.G. Trueman Road, Lusby, Maryland 20657

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 1 2007

32 Registrar's Signature

2. Date of Death 3. Time of Death AUGUST 5, Day 2007 6:10 A M PATRICIA SCHMTT7 BEVERLEY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Months Days Hours Min 1 □ M 2 T F Yrs. 11-14-1936 ENGLAND 422-56-1643 70 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d Inside City Limits 10b. County 10c. City. Town or Location 1 ☐ Yes 2X No Director ACCOKEEK MARYLAND PRINCE GEORGE'S 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20607 **ENGLAND** 16508 ROLLING TREE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █\No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: 2 3 Widowed 4 Divorced WHITE Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 MEDICAL ASSISTANT PHYSICIANS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HORACE CHARLES BAGOT KATHLEEN MARGARET BARLOW ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.BOX 188, ACCOKEEK, MARYLAND 20607 MR. RAYMOND D. SCHMITZ -SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition AUG 8 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEM. GARDENS 2007 WALDORF, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HUNTT FUNERAL HOME M00053 3035 OLD WASHINGTON RD., WALDORF, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to Examiner 00 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed g physician and as the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ♣ No 4□Pregnant at time of death
9□Unknown 5 Other (specify) PO 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn certificate 2 No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation injury 1 ☐ Yes 2 ☐ No hours after death. 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours af To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 30. Name and address 1328 completed cause of death (Item 23a) (Type, ire MO 32. Registrar's Signature 31. Date filed (Month State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Lucia Spector 1:20 p M 3, 2007 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Manor Care-Fernwood Bethesda Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 😿 F Yrs Director 578-46-6113 105 April 1, 1902 Austria Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "naturs!", or iteme 23a or 28a-f show the Medical Examinat must be notified at 1 ☐ Yes 2 No Maryland Montgomery Bethesda Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t 4800 Hampden Lane, 7th Floor 20814 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specia White 3XPWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ntal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelith and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 9DCB. 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven A. Widdes/Guardian 4800 Hampden Lane, 7th Floor, Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XCremation 3 ☐ Removal from State Metropolitan Crematory August 5, Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Filheral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Gangrene in Toes of Left Foot /Medical Due to (or as a consequence of): Examiner Rheumatoid Arthritis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit Osteoporosis Due to (or as a consequence of) Box 68760, Completed by Physician/Medical Dementia attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by tha a Ö 9 Unknown 9 Unknown نه Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Generalized Deconditioning 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has t irector, page 2 s 24a. Was an autopsy performed? 1 Yes 2X No. of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ctor: After this ce Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20274 August 3, 2007 102 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7710 Bradley Blvd., Bethesda, MD 20817 Kirti Vohri, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Mora & Speak Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Month **Physician** August 5, 6:00 Marjorie Winifred Smale a^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3114 Gracefield Road, cial Security Number 6. Sex RC #1224 Montgomery

9. Birthplace (State or Foreign Country) Silver Spring
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 1, st birthday) Ye*ar)* 1919 **Funeral** Days Months Hours 1 □ M 21 F 255-18-0744 88Yrs. Georgia Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County show 1 ☐ Yes 2K☐ No notified Director Maryland Montgomery Silver Spring 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or be i 20904 USA 3114 Gracefield Road, RC#1224 must Funeral items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or item: ledical Examiner n Black White etc. 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White þ 3 ₩ Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed withir Hygiene. than Elementary/Secondary (0-12) College (1-4or 5+) the Cash Manager Gas Company permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygis Important: If item 27 is marked other i any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Waco Bowers Maggie Williams ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2007 Tidewater Colony Drive, Annapolis, MD 21401 Joseph Selle/Executor of Will 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8, August Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. a 500 University Blvd, W. Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): executed burial-transi Exami Due to (or as a consequence of): P.O. Box 68760 physician requires that the death certificate be Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 Tes 2 No 3 Probably 4 Munknown page 2 should Completed Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed **⊀**₩ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA မ After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 🙀 Natural 2 🗌 Accident 5 Pending investigation Injury within 24 hours are control to the Funeral Director: A/ 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 💴 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) D24035 August 6, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road, Silver Spring, MD 20904 Eugenio Machado, M.D

State Registrar 31. Date filed (Month, Day, Year)

32. Pigistrar's Signature AUG 0 7 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** CC 26 7M Lynn 08 06 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner arroll weeth. - mades Comme 11 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 □ F Months Days Hours Min. 219-46-6414 61 Director ~ 5 Winchester, VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural", or items 23a or 28a-f shov dical Examiner must be notified at Adams PA Li Hisaptown 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? アマゲ レッナハマ 17340 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔼 No Maryland 21215-0036 Specify Specify: Uh. L 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gov't Contracts Secretary artment of Health and Mental Hygis ortant: If item 27 is marked other Injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Schweier ပ <u>Mae Jeffries</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 i Larry H. Eader, husband 325 Lexington Way Littlestown PA 17340

20b. Place of Disposition (Name of State) Baltimore, Carroll Crematory 8/7/07 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PA 17340 Little's F.H. 34 Maple Ave. Littlestown 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** 与いれたはしにこと herris /Medical Due to (or as a consequence of): Examiner Lereproci edena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine moto atotic Caler burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 □Ectopic pregnancy Month 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signatu and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIL 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Azicom Thompar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DIANE

				epartment of Health and Mer Certificate of Death	
			Decedent's Name (First, Middle, Last)		Reg. No. Dete of Deeth 3. Time of Death
	Physici		ELVA SCHUH		Month Dey Year 7 3:30 A
	/Medic Examir		4a Fecility Name (If not institution, give street and number) 1442 (300	Whorn Roll 4b. City, Town, or Location	
			BRINTON WOODS NUVSIN		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		Oate of Birth (Month, Day, Yeer) 9. Birthplace (State or Foreign Country)
	Director		154-16-3112 1□M 212F 83 Y	rs. Months Deys Hours Mill.	Feb 25 1924 Mass
	p .	'	Usuel Residence of Decedent 10a, State 10b, County 10c, City, Town	-1	
	anyla show	_	10a. State 10b. County 10c. City, Town Carroll	Westminster	10d. Inside City Limits
	Ba-f	8			1 ☐ Yes 2 ☐ No
	vith t	ä	10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
	ath v	ral	1217 Cherrytown Road	21158	USA
	er de Mem	n n	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?	 Was Decedent of Hispenic Origin? (Specify If Yes, specify Cuben, Mexicen, Puerto Rica 	Yes or No- n, etc.) 14. Race - American Indien, Black, White, etc.
36	rs aff	by Funeral Director	1 Never Merried 2 Married 1 Never Merried 2 Married 1 Never Merried 2 Married 1 Never Merried 2 Married 2 M	1 ☐ Yes 2 ☑ No Specify:	Specify: White
21215-0036	filed within 72 hours after death with the Maryland Hygiana. ther than "naturel", or Nerns 23a or 28a-f show ther than "naturel", or Nerns 23a or 28a-f show ont, the Madical Examiner must be notified at	8		Decedent's Usual Occupation	16b. Kind of Business/Industry
215	n n n	Completed	(Specify only highest grede completed)	Give kind of work done during most of working life. DO NOT use retired)	,
212	d with	E	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker	Own Home
	be file tel Hyg d othe event,	Bec	17. Father's Name (First, Middle, Last)		st, Middle, Maiden Surname)
<u>a</u>	uld by Aante rked tic e	ToE	Martin F. Cook	Amy Rupp	recht
Maryland	should land Manis market		19a. Informant's Name/Relationship (Type, Print) 19b. I	Mailing Address (Street and Number or Rural Ro	ute Number, City or Town, State, Zip Code)
	and 2 aalth a n 27 is		Linda Gregg/Daughter 683	9 Autumn View Drive 1	Eldersburg, MD 21784
ore	of Hariter	- 8	20a. Method of Disposition 20b. Place of L	Disposition (Name of crematory or other place)	ate 20c. Location - City or Town, State
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Hauth and Mantel Hygiana. Important: if item 27 is marked other than "naturel; or items 23a or 28a-f show any figury or other traumatic event, the Madical Examiner must be notified at once.		1 ☐ Surial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurre	ection Cemetery 8/13/2	007 Piscataway, NJ
alt	Departr Imports any inju		21. Signature of Funeral Service Licenses	22. Name and Address of Facility Pritts Funeral Home at	nd Chanel P A
m	80 5 5 8		Ment	412 Washington Road	
		\Box	23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart tailure. List only one cause on each line.		spiratory arrest, Approximate
	Physician		·	. ^	Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition Mekaskutic Cau	Cev. Vikion Porwae	> 1 Weer the
	Examiner		resulting in death) a. Due to (or as a co	cer, Unknown forward	
	D #	lie.	- 1		
	ficate ba axacuted physician end is tha bunal-trensit	edical Examiner	Sequentially list conditions, Due to (or es a co	nsequence of):	
60,	cian cian cunal	區	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury		
68760,	physic tha	gi	that initiated events resulting in deeth) Last Due to (or as e con	nsequence of):	
	eath certifi attanding I for use es		d		
Box	death certif e attanding ed for use es	Physician/M			
o.	0 0 0	N S	Part II. Other significant conditions contributing to death but not resulting in t	he underlying ceuse given in Part I.	23b. Did tobecco use contribute to the cause of death?
<u>α</u>	es that tigned by				1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Sp	requires that the veen signed by th hould be dateche	d by			24a. Wes an autopsy 24b. Were autopsy findings
Ö	_ 11 0	ete			performed? available prior to completion of cause
Re	e lay has	ompleted		4	of death?
of Vital Records,		O	25. Was case referred to medical		1 Yes 2 1 No
Ē		Ö	examiner?	26. Place of Death (Chartent 3□ DOA Other: 4☑ Nursing Home	
o	rthis eral di	-	27. Manner of Deeth 28a. Dete of Injury 28b. Tin	ne of 28c. Injury at 28d.	5 ☐ Residence 6 ☐ Other (Specify) Describe how injury occurred
Division	Afte of fun	흝	1 ☑ Naturel 5 ☐ Pending (Month, Day Year) Inju	ury Work? M 1 ☐ Yes 2 ☐ No	
<u> </u>	Atter r dee ector by th	<u> </u>	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm		ocation (Street and Number or Rural Route Number,
ā	al or	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, State)
	papita hours in fille	Sai	29a. Certifier (Check only Check only C	leath occurred at the time, date and place, and c	lue to the cause(s) and manner as stated.
	To the Hospital or Attending PP within 24 hours after deeth. To the Funeral Director. After it completely filled in by the funeral	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/one and manner stated.	or investigation, in my opinion, death occurred at	the time, date and place, and due to the cause(s)
	To the Foot		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	in		Paver /wesno	020806	818107
	WIO		30. Name end address of person who completed cause of death (Item 23e) (Ty	(pe, Print) / (a. f D1 <	-(A) -(1) 2/20
		N	MATRICK TURKS, and Suite (OZ /1	W WHILE Red 2	Killister my 4 +89
	Stat		31. Dete filed (Month, Day, Year) 32. Redistrer's Signature	1	J
	Registra	ir	AUG 0 8 2007 Menu &	Sparke	
DHN	IH 16 Rev 6/95			PRIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 4:300 erav nacion D3 200 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death 4c. County of Death Rockville, Mome Nursing MD Montgomer If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2XX 213-54-7351 93 March 25, 1914 Bolivia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 126 Duvall Lane, Apt. 304 20877 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status - American Indian, Black, White, etc. | ☐ Yes 2 X No f Yes, Give Year or Dates: 1 X Never Married 2 Married Specify: Bolivian 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Angel Teran Tomasa Lopez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Teran/Granddaughter 126 Duvall Lane, Apt. 304, Gaithersburg, MD 20877

20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 Toremation 3 ☐ Removal from State August 7, Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring _,MD 20901 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the disease, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

\$

Completed

Be ပ

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If tien 27 is marked other than "natural", or Items 23a or 28a-f show mortant: It in the 27 is marked oo other than "natural", or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

sician and burial-trans attending physician for use as the buria ed by the a signed by t certificate To the Hospira. . within 24 hours after deatn.
To the Funeral Director: Aft

Medical Certification: To

Division or Vital Records, P.O. Box 68760,

by Physician/Medical Examiner	if any, leading to immediate cause. Early Understand Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consecutive to (or a consecutive	ction							
nysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ OF OF OF OF OF OF OF OF OF OF OF OF OF	23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □Ector					23d. Date of de Month		Year
ted by PI	Part II. Other significant conditions of	ontributing to death but not rea	sulting in the underlyi	ing caus	se given in Part I.				o the cause of de	eath? Inknown
Completed							Was an autopsy performed? (es 211 No	prior to death?	utopsy findings a completion of ca s 2 ☐ No	available ause of
Be	25. Was case referred to medical examiner?				26. Place of De	ath (Check o	only one)			
0	1 Yes 2	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3] DOA	Other: ANursing I	Home 5	Residence 6	G □Other (Spe	ecify)	
ation:	27. Manner of Death Thatural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c.	. Injury at Work? 1 □ Yes 2 □ No		ribe how injury	y occurred		
Medical Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fa fy)	ctory, o	ffice	28f. Locat City o	ion (Street and or Town, State)	d Number or R	ural Route Numi	ber,
edical	29a. Certifier (Check only one) Certifying Ph 2 Medical Exam	ysician: To the best of my kniner: On the basis of examinand manner stated.	owledge, death occu ation and/or investig	rred at ation, in	the time, date and place my opinion, death occ	e, and due to urred at the	o the cause(s) time, date and	and manner a place, and du	s stated. e to the cause(s))
Σ	29b. Signature and title of certifier	2		29c. L	icense number		29d. Date	e signed (Mon	th. Dav. Year)	

Hospital or Attending Physician:

State Registrar

DHMH 17 Rev 1/2001

Grove Rd, Rockville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

AUG 0

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Richard Harvey Toms 12:52 A.[™] August 15, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown N.M.S Health Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Oct. 14, 1938 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 1 XM 2 ☐ F 68 214-36-1458 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Md. Washington Smithsburg ral", or items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21783 11807 Wolfsville Rd. U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status : 1 and 2 should be filed within 72 hours after thealth and Mental Hygiene.

tem 27 is marked other than "natural", or iter ther traumatic event, the Medical Examiner. Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Forklift Operator Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ward Toms Orpha Buhrman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ruby M. Braithwaite (Sister) 435 N. Prospect St. Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages nent of I permit. Pages Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Brown Cemetery 4 Donation 5 Dother (Specify) 2007 Foxville, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 M01414 <u> 4vis</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death N. SCasa Immediate Cause (Final Physician COYUNDAY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner xst: 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner DISCASL Rinal attending physician and for use as the burial-transit Chron. Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 page After this certificate 1□ Yes 2 - No Physiclan: director, 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 ☐ Pending investigation 1 Natural To the reception within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7060396 107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Opal Court Hagtistown Ins 21740 Fariel Murshed

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year CHARLES TWIGG 08 /Medical 5 2007 1957 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Year) Jan 13, 1909 5. Social Security Number 6 Sev If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours ¥ M 2 □ F MD Director 214-05-8181 98 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at Cumberland 1. ☐Yes 2 ☐ No MD Allegany Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be n 604 Wellington Lane 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. <u>ک</u> Specify: 3√ Widowed 4 Divorced white Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>serviceman</u> Columbia Gas 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary V. Shryock Twigg Dennis Twiaa ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 604 Wellington Lane Cumberland MD 21502 Loay 'Bud' Twigg son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 8/16/2007 MD 4 □ Donation 5 □ Other (Specify) Cresaptown 21. Signature of Flineral Sorvice Licenso 22. Name and Address of Facility Scarpelli Funeral Home, PA Mille 108 Virginia Avenue: Cumberland, MD 21502 23a intl. Inter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one carb on each line. Immedia e Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): **Examiner** Myscard Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 200 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 22 No 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Inpatient Certification: To 1 Tyes 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Matural 2 ☐ Accident funeral Date of Injury (Month, Day Year) 28a. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,で the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: filled in by the completely

Medical

31. Date filed (Month, Day, State Registrar

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

32 Registrar's Signature

AUG 2 1

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

265

Grantsville, MD

29d. Date signed (Month, Day, Year)

21536

State of Maryland / Department of Health and Mental Hygiene #19B Certificate of Death 1. Decedent's Name (F 2. Date of Death 3. Time of Death **Physician** Month Wayne Williams 8 9:45 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 314 Mill Pond Lane, Apartment 423 Salisbury
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Wicomico 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□ F Months Director 220-52-2258 57 6-24-1950 Maryland Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other than "natural", or iteme 23s or 28s-f shovent, the Medical Examiner must be notified at 1 Yes 2 No MD Wicomico Salisbury Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 Mill Pond Lane 21804 death USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1XIYes 2 □ No 1970— If Yes, Give Year or Dates: 1972 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify by Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Compi Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. LPN - Orthopedic Nurse 10 Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental 27 is marked or traumatic ever ပ Frederick Williams Bettie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **Layla** Lyla Williams – daughter 9377 Bel Air Drive, Mardela Springs, MD 21837 item 27 li other tra 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Shad Point Cemetery 8-9-2007 Shad Point, Maryland 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee 705 E. Main Street, Salisbury, Maryland 21804 enes 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** sieed GI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 robably 1 Yes 2 No 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has brieded in rector, page 2 s autopsy performed 2 No 1 Yes 2 No 1 Tyes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3ET DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury after death.

Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 3 □ Suicide 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide ō Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 4 mg H5049) 81110 30. Name and address of person to completed cause of death (Item 23a) (Type, Print) VA lisbu 100 E Carrolls W 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2007 AUG 0 Registrar

DHMH 17 Rev 1/2001

			Please	Type or Print					-	_	ble.	
			For State Registrar	State of Mar	yland /	•	irtment of F tificate of		-		1 * 1	.5.2-
ı		-	Hegistrar Decedent's Name (First, Middle, La	st)			tinoato or i	504	2. Date of De		1	3. Time of Death
	Physicia /Medic		Helen Shirley W	hite					August	Day 3 20	Year 207	2:28 AM
	Examin	er	4a. Facility Name (If not institution, giv Mandrin Hospice				*	r Location of Deat cwood	h	4c. County Anne		
	Funeral		Social Security Number 6. S	ex 7. Age (th		place (State or Foreign					
	Director		349-20-9200	□ M 2 X F	85	Yrs.	Months Days	Hours Min.	Feb. 1		000	Canada
	land ow		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, To	wn or Loc	cation					10d. Inside City Limits
	e Man a-f sh tifled	ctor	Maryland Anne Ar	rundel			Ar	nnapolis				1 XYes 2 No
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Director	10e. Street and Number 7101 Bay Front D	rive, #308			10f. Zip Code	21403		10g. Citizen of	What Cou	
	death ms 23	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No)- 14. Rac		ican Indian,
õ	s after or Ite	by Fu	1 Never Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give			Yes 2XXXVo	Specify:	to rican, etc.)	Specif	ck, White, v: Wh	ite
215-0036	hours atural"	ed p	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	16	a. Deced	ent's Usual Occup	pation		16b. Kind of B		
<u>دا</u>	thin 72 ie. an "na Media	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)		(Give i life. E	kind of work done OO NOT use retired		rking			
121	iled wi Hygien her th nt, the	Con	17. Father's Name (<i>First, Middle, Last</i>	4			Homema)		ne (First, Middle		wn Ho	ome
yland	ild be f lental h rked ot ic ever	To Be	Howard E. Hyde	,					Black	, warden odmar	10)	
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	_	19a. Informant's Name/Relationship (Barbara L. Holco				g Address (Street • Fairvie					
e,	of Hea of Hea of Item		20a. Method of Disposition	Demoual from State	20b. Place cemet	of Dispos tery, cren	sition (Name of natory or other plac	ce)	Date	20c. Location	- City or T	own, State
Baltimore,	Pag tment tant: I		1 ☐ Burial 2 ☐ remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Contr	y)	Baltir		Cremato	- 1	/2007			Maryland
g	permit Depar Impor any in		21. Signature of Juneral Service luce	nsee			Name and Addre			-		MD 21401
ı			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	ne death. Do					<u> </u>	1220	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ig Cano	cer						Onset and Death 4 months
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	e of):						
+		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a c	consequence	e of):						
	oe executed cian and ourial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a c	consequence	ot).						
68/60 ,	death certificate be executed e attending physician and d for use as the burial-transit	_		d	onocqueno	0 017.						
	rtificat ng phy s as the	Medi	IF FEMALE:									
gox	death certificate be attending physicia for use as the bu	Physician/Medica	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf 1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal dea		Ectopic pregnancy Other (specify)	у		1	ate of deliv	very Day Year
Ċ	the de	hysic	1 □Yes 2 🖾 No 9 □ Unknown	9□Unknown	me or deam	J_	Other (specify)					
as, r	The law requires that the diate has been signed by the page 2 should be detached	by	Part II. Other significant conditions	contributing to death but	not resulting	in the ur	nderlying cause giv	en in Part I.				the cause of death?
cords,	law requas been 2 should	Completed							24a. Was		Were au	topsy findings available
T T	The la ate ha	omic							auto perfo 1∐ Yes	prsy prmed? 2 No	prior to co death? 1 □ Yes	ompletion of cause of 2 \(\frac{1}{2}\)\(\text{No}\)
VItal	Physician: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?	Hospital:			t 3DDOA Oth	or.	ath (Check only			e House
0	ding Phys n. After this funeral dii	1: To	1 ☐ Yes 2XX\lo 27. Manner of Death	28a. Date of Injury		. Time of	t 3 DOA 28c. Inju	4 🗆 Hursing i	dome 5 ☐ Resi 28d. Describe	idence 6 🖾 Otl how injury occur		sify)
VISION	Attending r death. ector: After by the fune	atio	1X Natural 5 ☐ Pending 2 ☐ Accident investigatio		rear)	Injury		Yes 2 □No				
Š	or Att after de Direct in by t	Certification:	3 Suicide 6 Could not b 4 Homicide determined		- At home, ((Specify)	farm, stre	eet, factory, office			Street and Numi wn, State)	per or Rui	ral Route Number,
_	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical Co		nysician: To the best of miner: On the basis of e and manner state	xamination a							
	To the within 3	Mec	29b. Signature and title of certifier	and marrier state			29c. Licens			29d. Date signe		n, Day, Year)
)	and	7	1	NX			DO	0064379		8/3/2	2007	
	Sp	,	30. Name and address of person who Jay Rhee 900 B	completed cause of dea				apolis, M	Maryland	21401		
į	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 6	32. Fi gistrar'	s Signature		book	•				
1		_				-/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Roland Chamber Worrell, Jr. 2007 August 4 8:05 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1 Raft Rd. Ocean Pines Worcester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days 1**X**M 2□F Months 220-98-5323 44 1963 June 18, Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√CXNo Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Raft Rd. 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 🔀 No 1 ☐ Yes 2 X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Radio DJ Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roland Chamber Worrell, Sr. Florine Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patty Worrell Raft Rd., Ocean Pines, Md.21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 8/6/2007 Frankford, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility The Burbage: Funeral Home 108 William St., Berlin, Md. 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2**☑**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner Examine

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other than any Injury or other traumatic event, the ones.

Physician

/Medical

Examiner

Director

Funeral

Completed by

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Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Physician/Medical

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Completed

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Certification:

Medical

attending physician certificate | After this

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

1∐Yes 2∐No 9∐Unknown	
Part II. Other significant condition	1 s co
1) jabr	ga
Malignan	

Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

29a. Certifier (Check only one)

1 Prestifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year) Aug. 6, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven E. Hearne

31. Date filed (Month, Day, Year)

106 Milford St., Salisbury, Md. 21804 32. Registrar's Signature

State Registrar

AUG 07 2007

24 hours a e Funeral I

within 2

BA5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Audrey L. Williams 3 2007 August 11 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Presbyterian Home of MD, Inc. Towson Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🕶 F Director 217-12-5031 82 Jun 12, 1925 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at ral", or Items 23a or 28a-f sh Examiner must be notified 1 ☐Yes 2XINo Director MD Howard Woodstock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10349 Wetherburn Rd. 21163 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: natural", or Specify. White 1 ☐ Yes 🏖 No Specify: þ 3∑ Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mone. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Alt Flora Vaughn ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10349 Wetherburn Rd. Woodstock, MD 21163 Susan F. Massuda/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8/7/2007 Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service MOIO 19 22. Name and Address of Facili Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pk Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ➤ No 24a, Was an autopsy performed? Yes 2 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation within 24 hours after death. To the Funeral Director: Accompletely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

(10)02

State

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier Attending My

and manner stated.

29c. License number 137016

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Cherles H., B. Anore, my 21209 Leaveth in. Greene,

31. Date filed (Month, Day, Year) 32. Regetrar's Signature

7 200 AUG 0

Registrar

		1 _ State	aryland / Depa	artment of I <i>rtificate of</i>			F (1)	Mark District					
EVIE :		Registrar 1. Decedent's Name (First, Middle, Last)		Timodic of	Dodin	2. Date of De		3. Time of Death					
Physicia /Medic		Mary Priscilla Walku	ρ			Month 08	03 2	2007 10:45 AM					
Examin		4a. Facility Name (If not institution, give street and number)			or Location of Deat	h	4c. County						
		University of Mayland Medica 5. Social Security Number 6. Sex 7. Ac	e (In yrs. last birthday)	Bullim.		8. Date of Bi	N/4						
Funeral Director			36 Yrs.	Months Days		6/23/	ay, Year)	9. Birthplace (State or Foreign Country) Virginia					
p _L		Usual Residence of Decedent				10/23/	1941						
lanylau show	ž	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ▼No					
the M 28a-f notifie	Director	Md. Howard 10e. Street and Number	Columb	10f. Zip Code			10g. Citizen of V						
3a or	Ö	8610 Snowden River Pkw	у.	2104	15		U.S.A	•					
d 21215-UU36 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 □ If Yes, Give Year or Dates:	No	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S can, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)	14. Rac Blac Specify	ce - American Indian, ck, White, etc. y: black					
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	Be	17. Father's Name (First, Middle, Last) Willie Blair			18. Mother's Nar		, Maiden Surnan	ne)					
Maryland nd 2 should be file lith and Mental H 27 is marked oth r traumatic even	2	Willie Blair 19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Stree	t and Number or Ri			State, Zip Code)					
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Baltimo permit. Page Department of Important: If any Injury or		21. Signature of Funeral Service Mensee	41	1 Kenne		NW Was	hingto	uary n, DC 20011					
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EOX 68/60, eath certificate be executed attending physician and for use as the burial-transit	M/ug	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		⊒Ectopic pregnanc	TV.			ite of delivery					
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	Completed	Renal failure				24a. Was	psy	Were autopsy findings available prior to completion of cause of					
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VITAI HEC sician: The law certificate has lirector, page 2 s	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatie		ot Ot	26. Place of Dea								
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ath. or: Aft	atio	1 X Natural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	y Year) Injury		ork?]Yes 2 □No								
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of inj building, et	ury - At home, farm, str tc. (Specify)	reet, factory, office			Street and Numb wn, State)	ber or Rural Route Number,					
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To th within To th	Me	29b. Signature and title of certifier			se number			ed (Month, Day, Year)					
/		Thomas J. Mirkle, M.D.		181	62		8/3/	2007					
6		30. Name and address of person who completed cause of d	Swith Greens	Street	Rollin	iore, MD	21201						
Sta	e	Thomas J. Merkle 22 3 31. Date filed (Month, Day, Year) 32 Registr	rar's Signature	JITCCI	الإرابات	, , , , ,	21201						
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		,	1 - For State Registrar	State of N	aryland		artmen			and M	lental Hyg	eg. No.	7	25503
			Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month		Year	3. Time of Death
ı	Physicia /Medic		Zarina	Akhtar	Alvi						8 1	9 ^{Day} 2007		2:00p ^M
п	Examin		4a. Facility Name (If not institution	n, give street and numbe	r)		4b. City,		Location of	of Death		4c. County		
			1111 Saddle	Creek Cour	t		If Under	Spa	rks If Under	24 Hrs	8. Date of Birth		ltim	ore place (State or Foreign
	Funeral		5. Social Security Number	6. Sex 7. A 1 ☐ M 2 ☑ F	ige (In yrs. las 66	t biπnday) Yrs.	Months	Days	Hours	Min.	(Month, Day	1941	Cou	India
	Director	}	216-80-1724 Usual Residence of Decedent											
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	Ba-fs	Director	MD Balt	imore		parks						0.000	15-1-0-	
	with th	Dire	10e. Street and Number				10f. Zip	211	E 2			Og. Citizen of V	SA	intry:
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9	ral', o		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	S:		1 🗆 Yes	2 LI NO	Specify:			Specify	As	sian
20	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show he Medical Eventries must be rigilified at	Completed by	15. Deceden (Specify only highe	t's Education st grade completed)		(Give	dent's Usua kind of wo DO NOT us	rk done d	during mos	t of work	ing	16b. Kind of Bu	siness/l	ndustry
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d 2	be filed tal Hygie d other event,		12th 17. Father's Name (First, Middle,				One				e (First, Middle,			
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Maryland 21215-0036	2 should and Men is marke sumatic		19a. Informant's Name/Relations								al Route Numbe		State, Z.	
	and 2 ealth m 27		Muhammad S. I	Alvi—husband			L Sado psition (Nar		creek		Sparks Date	20c. Location -		
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Importent: if item 27 is marked other than "netural, or Items 23a or 28a-f show my injury or other traumatic event, the Medical Examinating the multibulation and page.		20a. Method of Disposition 1 → Burial 2 □ Cremation		cen Kin	netery, created Mer	matory or o	The colac	řk ¦		/2007	Baltimo		
語	permit. Page Department o Importent: ff any injury or once.		 4 Donation 5 □ Other (S 21. Signature of Funeral Service 				2. Name an			ty M	ARCH FU	JERAL HO	ME-I	WEST
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Division	l or Attending after death. Director: Afte I in by the fune	ertification;	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	Injury - At hom etc. (Specify)	e, farm, st	reet, factor	y, office			28f. Location (S City or Tow	itreet and Numb n, State)	er or Ru	ral Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier (Check only one) Certifyii 2 Medical	ng Physician: To the be Examiner: On the basis and manner	of examination	edge, deat in and/or in	nvestigation	i, in my o	pinion, dea	nd place, ath occur	red at the time, o	date and place,	and due	to the cause(s)
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	5		30. Name and address of person	who completed cause of	of death (Item 2	(Type 10	Print)	Hop	Kine	CAY	uca G	NAR	13	21265
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			For State Registrar	State of Maryland / D	Department of He Certificate of D		tal Hygien Reg. N	SUBJE	26903		
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	he Mary 28e-f sh	Director	Maryland Prince Geo	orge's Ter	nple Hills		10a. C	itizen of What Cour	1 ☐ Yes 2 ☐ No		
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920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "neturel", or Items 23a or 28e-f show importent: If Item 27 is marked other than "neturel", or Items 23a or 28e-f show apply injury or other treumatic event, the Medical Evarities fraints the codified at an once.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 □ No WWII If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cuban 1 Yes 2 No	panic Origin? (Specify , Mexican, Puerto Ricar Specify:	Yes or No- n, etc.)	14. Race - Americ Black, White, Specify: Whi			
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212	filed within Hygiene. Other then ent, the M	Comp	Elementary/Secondary (0-12)	College (1-4or 5+) E	lectronic Eng	gineer		Electron	nics		
land	ould be fill Mental Hy arked oth atic even	To Be	17. Father's Name (First, Middle, Last) James A. Arneson	ı		18. Mother's Name <i>(Fir.</i> Mabel C		in Surname)			
Maryland	2 should and Men Is marke reumatic	-	19a. Informant's Name/Relationship (Typ		. Mailing Address (Street a				Code)		
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Baltimore,	permit. Pages Department of I Importent: If Its any injury or o'		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Fo	orestville, MD						
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119	cate be executed whysician and physician and the buriat-transit the buriat-transit	Examiner	23a. Reft1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								
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Δ.	juires that t n signed by ild be deta	þ	Part II. Other significant conditions con	tributing to death but not resulting is	n the underlying cause give	n in Part I.	23e. Did tobacco		the cause of death?		
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Vital	Physicien: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	ospital: 1 ☐ Inpatient 2 DER/Ou	utpatient 3 DOA Othe	26. Place of Death (Cl		6 □Other (Speci	ify)		
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	edical Cer	(Check only 2 Medical Examin	sician: To the best of my knowledge her: On the basis of examination an	e, death occurred at the tim	e, date and place, and inion, death occurred a	due to the cause t the time, date a	(s) and manner as ind place, and due	stated. to the cause(s)		
	To the P within 24 To the F complete	Med	29b. Signature and title of certifier	and manner stated.	29c. License	number	29d. [Date signed (Month	Day, Year)		
	4		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print)	06054 695 0	Ame	rica	21035		
	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 2 20	32. Fegistrar's Signature	Barto						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year August Μ. 9.44 PM Angela Bryant 17 /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore Cita of Baltimore if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex J 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days Hours Min. Director 213-34-9764 68 MD Usual Residence of Decedent a or 28a-f show the notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director X ☐ Yes 2 ☐ No MD NA Baltimore Pages 1 and 2 should be filed within 72 hours after death with the nent of Health and Mental Hygiene.
unt: If item 27 is marked other than "natural", or items 23a or 28a. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a c il Examiner must be Completed by Funeral 4019 Belle Ave 14. Race - American Indian, 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√2 No If Yes, Give Year or Dates: Specify: 3 XWidowed 4 ☐ Divorced Black d Hygiene. d other than "natura event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade House Keeping item 27 is marked othe other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ William Hoard Sr. Catherine Laws 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Gaskins-Daughter 4019 Belle Ave, Baltimore, Md permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other: Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 8/24/07 Owings Mills, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Drine - hom 4300 Wabash Ave, Baltimore, Md 23a. Part1. Inter the disease, or complications that cau led the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Mesotactiona Q WEEKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnan-in the past 12 months? 1 ☐ Yes 2 Ø No 23d. Date of delivery 3 Ectopic pregnancy detached for Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Kulmonan Chronic Obstructive 1 ☐Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Hypertension 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No Diabetes 2 No Mellitus 1□ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Mary er of Death 1 Natural filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After Attending 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 0 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca and manner stated. within 2 To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number RES-500 MIS 200 Hugust 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryand Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Margaret Bishop /Medical Aug 17. 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 □ Director 259 36 2923 Nov 26, 1924 Georgia Usual Residence of Decedent 10b. Counfy 10c. City, Town or Location "natural", or items 23a or 28a-f show idical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No XX Director Maryland | Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6519 Horseshoe Road 20735 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes **②**No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William W. Mulkey Mary L. Entreken of Health and N Item 27 Is ma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Jean Bishop (Daughter) 6519 Horseshoe Road, Clinton, MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If Ite
any Injury or ot
once. Lee Crematory Aug 22, 2007 Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service License 70015 Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the dead. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Completed by Physician/Medical as the l IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month ed by the a detached for 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2√☐ No 9 ☐ Unknown 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1☐ Yes 2☐ No Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes After this certificate 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sip Arous, M.D. 1170/ livingsfor n/ #/0/ foot WAFLista Mo 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 08 16 2007 17:30 PMM /Medical Ruby Norris Blair 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 212 F **Director** 03/14/1936 218-32-7276 Maryland death with the Maryland 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be r 418 Village Drive 21078 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Completed by Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Production Saks Fifth Avenue 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 is marked of William Payton Ruby Frank 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - Aberdeen, Maryland Andy H. Blair (son) Parke Street 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State injury or ew Memoriai Gu 00,20,20. 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A.

Warvland 21087 Highview Memorial Gd 08/20/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses E. A 11750 Belair Road - Kingsville, Maryland a . Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Severe prievmonio disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Terminal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> fibrillation Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 No 1∐ Yes To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 63420 August 16,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. Zubair Knaral 500 upper Chesapeake In Bel Air MD 21014

State Registrar 31. Date filed (Month, Day, Year)

AUG 2

2 2007

DHMH 17 Rev 1/2001

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician August 21 2007 Fritzi Benda 2:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Baltimore County Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth April Day Social Security Number 7. Age (In vrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 546 40 9617 Days Hours 1 □ M 2 🔀 F 74 ea 1933 Vienna Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28e. *** one once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 □ No X Director Baltimore County Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4303 Ridge Road 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X X**No If Yes, Give Year or Dates: 1 ☐ Never Married XX Married 1 ☐ Yes 2CXNo Specify. þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Bo</u>okkeeper Dr Barry Blum 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Seebauer Josephine Machacek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J Benda 4303 Ridge Road Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Moreland Memorial Park Aug. 24 2007 Baltimore, Maryland 21. Sign tur of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
M. M. M. S. Immediate Cause (Final disease or condition resulting in death) MICER **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and physician and s the burial-trans Due to (or as a consequence of): Physician/Medical aftending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury in 24 hours area the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 7 address of person who completed cause of death tem 23a) (Type, Print)

State Registrar

Division or Vital Records, P.O. Box 68760,

70 6

32. Registrar's Signature

Year)

31. Date filed (Month, Day,

07-06321 Kelvin Bennett

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ 0055 hrs Medical Examiner August 16, 2007 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** Sinai Hospital If Under 24Hrs, 8, Date of Birth(MM/DD/YYYY) 9, Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Director Country) 78-1136 1**X** M 2 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 or 28a-f show s 23a or 28a-f shov e notified at once, Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 Married Yes 2 X No Divorced If Yes, Give Year Yes 2 X No specify: Widowed nt: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner \$ Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours Department of Health and Mental Fygiene. 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+ Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be 19b. Mailing Address (Street and Number or Rural Route Number, City o own, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 Other Specify. 22. Name and Address of Facility Funeval Home hat man-Harris Funeval Home 5:44-448 21. Signature of Funeral Service Coensee and. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Cocaine and heroin intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED ^{AMENDED} 27,28a-f, perME, g870, 8/30/07 TT attending physician for use as the burial Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Ectopic pregnancy Day Live birth detached for use as Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other₄ Hospital: 1 ER/Outpatient 3 V DOA Inpatient Nursing Home 5 Residence 6 this 1 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: To the Huspans after death.

To the Funeral Director: A Natural Yes 2 X No Pending unk Fnd 8/16/2007 Fnd 12:00 am 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Could not be Suicide 3754 Dolfield Ave.Baltimore, MD determined (Specify) found in residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. August 16, 2007 Deasell More 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 31. Date filed (Applie Day, Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

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2007

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Hugust 19 110 D Emma MON 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Stella BAITIMORE HOSDICE . Age (In yrs. last birthday If Under 5. Social Security Number Birthplace (State or Foreign Country) 1□ M 2 F 80 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 THO Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3802 . Was Decedent Ever in Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Granpler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ORRISON CONARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 02635 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley - Ashton Funeral WILLOW SDrING Rd Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2**X** No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{X} \) Other (Specify) \(\text{HOSPICE} \) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

oermit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heath and Mental Hydiene. Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran P.O. Box 68760. ed by the a signed by the Records. Division or Vital To the Hospital or Attending Physician: After this 24 hours a within 2.

To the F

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

Be Completed by Funeral Director

2

Examiner

Physician/Medical

Be Completed by

To

Certification:

Medical

MARION BARTON

State Registrar

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

AUG 2 2

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

And

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3 Time of Death DREWSTER 1108 PM **Physician** BAVGH DANIEL 08 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CHITTENDEN LANE OWINGS MILLS If Under 24 Hrs BALTIMORE 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1 17237 1923 1XM 2□ F 213-20-7744 83 MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Director MD BALTIMORE 1 ☐ Yes 2 X No OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 CHITTENDEN LANE 21117 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Mayres 2 □ No If Yes, Give Year or Dates. 42 – 1972 1 Never Married 2 Married or i 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WHITE ģ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) U.S.SENATOR U.S.SENATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental H DANIEL BAUGH BREWSTER OTTOLIE WICKES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any Injury or other trau GERRY BREWSTER son 527 ALLEGHENY AVE. TOWSON, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State AUG 21,2007 GREEN MOUNT BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HENRY W. JENKINS & SONS CO 21. Signature of Funeral Service Licensee 16924 YORK RD. MONKTON, MD 21111 OND CE 23a. Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line, Immediate Cause (Final Physician Metastatic disease or condition resulting in death) /Medical Examiner Conall coll a Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician a s the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending -NA 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral D To the Hospital 29a. Certifier retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and matrice as dates. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

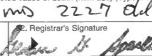
State Registrar

DHMH 17 Rev 1/2001

A. WILSON LANKY 31. Date filed (Month, Day, Year)

AUG 2 2 2007

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Emmorton Rd, Bel Air, MD 21015

D26253

	1 - For State Registrar	State of Mary		artment of I		Mental Hy	giene Reg. No.	0.07						
ian	Decedent's Name (First, Middle, Las	st)			Berger	2. Date of De Month	eath Day	Year 2007	3. Time of Death					
ical iner	4a. Facility Name (If not institution, give	Kins Hosp	ital In yrs. last birthday 82 Yrs.	4b. City, Town,	or Location of Deat	unty of Death	place (State or For							
	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or L	ocation		01/16/			0d. Inside City Lir					
Director	MD N/ 10e. Street and Number	Α	BALTIM	ORE 10f. Zip Code			10g. Citizen	of What Cour	1X Yes 2 □					
by Funeral D	3016 FALLSTAFF R 11. Marital Status 1 Never Married 2 Married 3 Nowldowed 4 Divorced	12. Was Decedent Eve Armed Forcas? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cut		Specify Yes or No to Rican, etc.)		USA Race - Americ Black, White, ecity: WHI	etc.					
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To Be C	17. Father's Name (First, Middle, Last) SAMUEL		ARONOV	ITCH	18. Mother's Na	me (First, Middle	, Maiden Sur	*	BTAINABL					
-	19a. Informant's Name/Relationship (** BRIAN ASCH / SON	Type. Print)		ing Address (Stree			per, City or To		Code) 21208					
	20a. Method of Disposition 1 Burlal 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	ĻE	WETERY	08/2	Date 1/2007	BALTI	on - City or To	MD					
	21. Signature of Funeral Service Licer	see		22. Name and Addr 8900 REI	ess of Facility STERSTOW	SOL LEVI N ROAD -								
cal Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last	b. Due to (or as a co	onsequence of):	iei iie mode oi dy	ing, such as carda	c or respiratory a	illest,		Approximate Interval Between Onset and Death					
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) Month								ery Day Year					
þ	Part II. Other significant conditions of Diabetes Mell	_	ot resulting in the	underlying cause gi	ven in Part I.		tobacco use o		ne cause of death					
Completed						24a. Was auto perfo 1∐ Yes	psy ormed?		psy findings avail mpletion of cause 2 X/No					
To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	2 ER/Outpatie	ent 3 DOA Ot	har:	ath <i>(Check only c</i> dome 5 ☐ Resi		Other (Specia						
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edical Cert														
Med	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon													
	1102111		A	10	~ ~ ~	Physician RES-000 August 18, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Kostis, Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, MD 21287								

		4	For State	State of N	/larylar		artment of			lental Hy	/gien	ne		
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	edica		James E. Baldwi 4a. Facility Name (If not institution, give		r)		4b. City, Town,	or Location	of Death	08-18-		1c. County of De		:30 p ^M
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Funo	rol .		5. Social Security Number 6. S	iex 7. /	Age (In yrs.	last birthday			24 Hrs.	8. Date of B	irth	9. B	irthplace	(State or Foreign
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aryland 21215-5-0035 should be filed within 72 hours after death with the Maryland not Mental Hyglene. In marked other than "natural", or items 23a or 28a-f show unatic event, the Medical Examiner must be notified at		Lalleral	11. Marital Status	12. Was Deceder	s?	l.S. 13	Was Decedent of If Yes, specify Cu	f Hispanic Or uban, Mexica	rigin? (Spo in, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - An Black, Wh		ndian,
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1215-0036 within 72 hours af ene. than "natural", or the Medical Exami		5 -	15. Decedent's Ed		·-	16a, Dec	edent's Usual Occ	unation			16h.	Kind of Busines		
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Mary d 2 shou th and N 7 is mai	ľ	_	19a. Informant's Name/Relationship (Type. Print)		19b. Mai	ing Address (Stree	et and Numb	er or Run	al Route Num	ber, City	y or Town, State	, Zip Co	de)
₹2₫g ≤			Gregory Baldwin	(Son)		2419) Vineyar	d Lan	e Cro	ofton,	MD	21114		
SS 1.8 of He is			20a. Method of Disposition	15		Place of Disp	osition (Name of ematory or other p	lace)	[Date	20c.	Location - City	or Town,	State
Page Page Int: If			1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		te I		idge Ceme		08-22	2-2007	Ba	1timore	, Ma	ryland
Baltimore , permit. Pages 1 ar Department of Hea Important: If item 3	e e	ı	21. Signature of Funeral Service Lice	1529		- 2	22. Name and Add	lress of Facili	ity Sch	nimunek	Fur	neral Ho	me o	f Bel Air
n aaes	Б		146	9			Inc. 610	W. Ma	cPha	il Rd E	8e1 .	Air, MD	210	14
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus one cause on each	ed the deat line.	th. Do not e	nter the mode of d	ying, such as	s cardiac	or respiratory	arrest,		Ap Int	proximate erval Between
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. BOX 68 / 6U, death certificate be executed e attending physician and of for use as the burial-transit	3	200		d										
BOX gath certi	100		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor								23d. Date of c	leliverv	
death atte		2	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant	at time of o		□Ectopic pregnar □ Other (specify)					Month	Day	y Year
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ଅନ୍ଦ୍ର										aut per 1□ Yes	opsy formed2 2	prior t death	ocomple ? es 2∐	
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OF VITA Physician: this certific ral director,	, P	5	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpa	ntient 2 □] ER/Outpatie	ent 3 DOA	other:	ursing Ho	ome 5□Res	sidence	6 Dether (S)	pecify)	hospice
ng Ph ter th			27. Manner of Death 1 Natural 5 Pending	28a. Date of I	njury Day Year)	28b. Time Injury	of 28c. In	jury at ork?		28d. Describe	how in	jury occurred		
ath. or: Af			2 Accident investigation	1		,,,,,,		□Yes 2□]No					
DIVISION I or Attending after death. Director: After in by the fune		=	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of building,	njury - At h etc. (Speci	ome, farm, s	treet, factory, offic	е		28f. Location City or To	(Street	and Number or	Rural Ro	oute Number,
ital or set in the control of the co	8	5												
Hosp 24 hou Fune tely fil	. 3	2	29a. Certifying Pr (Check only one) 2 Medical Exam	nysician: To the be miner: On the basis	of examina	owledge, dea ation and/or	ath occurred at the Investigation, in m	time, date a y opinion, de	ind place, eath occur	and due to th red at the time	e cause e, date a	e(s) and manner and place, and d	as state lue to the	d. e cause(s)
LIVISION OF To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director		Medical	29b. Signatur# and title of certifier	and manner	stated.		29c. Lice	nse number			29d F	Date signed (Mo	nth. Dav	(Year)
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97		-	yer one	JAN	Edecti ()	00 -> /=		00519	166		لك	ugust	17	2001
0			30. Name and address of person who	- 0	1 ~	n 23a) (Туре 755-W	(Ones	100 <	4 0	- M -		~ 111	5	Vaci
D	State	,	31. Date filed (Month, Day, Year) -	- ' '	strar's Sign			0 0	1 2	e cho	ALCA	- Com		1 6 1
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** August 18, 8:35 A Vivian A. Behr 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore Baltimore Franklin Woods 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Months Hours Min. 1 □ M 2 🛛 F Yrs. Director Märyland 216-16-2467 84 March 1, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director **Baltimore** Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21236 U. S. A. 9309 Carlisle Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Telephone Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Charles Piotrowski Josephine Rapert ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Douglas Behr (Son) 7451 Bradshaw Rd., Kingsville, Md. 21087 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 08/21/2007 Baltimore, Maryland Parkwood Cemetery 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 9705 Belair Rd., Nottingham, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) emer Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy ō in the past 12 months? 1 □ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign 3 be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an NOTA Tailure 1 Yes 2 4 NO director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 1 Yes within 24 hours after death.

To the Funerel Director: After th completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel L To the Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 6cminelaux 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste. 312, Bathimore, MD 212 Franklin Sylvere Dr. Idmondson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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07-06366	Please Type or Print in Bla	ack Indelible	Ink. Ensure All Copie	s Are Legib	le.			
Ramona H. Bradley State of Maryland / Department of Health and Mental Hygiene								
	For State	Certificate of	of Death	Reg. N	lo.	107 5		
Physician/ 1	. Decedent's Name (First, Middle,Last)			2. Date of Death	v Year	3. Time of		
Medical Examiner	Ramona Hope Bradley			Month Day August 17, 20	07	1529		
48	a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of	Death		
1	Johns Honkins Rayview Medical Center		Baltimore		-			

		- For State Certificate legistrar	e of Death		ı. No.	7 2552
Physicia	n/	1. Decedent's Name (First, Middle,Last)		Date of Death Month	Day Year	3. Time of Death
ledical Examin		Ramona Hope Bradley		August 17,	2007	1529 hrs
		4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center	4b. City, Town, or Location of I	Death	4c. County of Death	
				OALLS To Date of Right	(MM/DD/YYYY) 9. Birth	uniaco (Stato or
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 212-80-1588 1 M 2X F 40	y) If Under 1 Year If Under 2 Months Days Hours Yrs.	Min.	Foreign	
> 1 (1) 1 (1	<i>~</i> .	Usual Residence of Decedent 10a. State 10b. County 10c. City; Town or I	ocation			10d. Inside City Limits
Aaryland 28a-f show any 1 at once.	ě	Maryland N/A	Baltimore	10.33		1 X Yes 2 No
the N	Director	10e. Street and Number 914 Spangler Way	10f. Zip Code 21205	10	g. Citizen of What Coun	
eath with items 23 ust be no	Funeral		B. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P		14. Race - Americ White, etc.	an Indian, Black,
fter d	- 1		1 Yes 2 X No specify:		Specify: Wh	ite
ours a	ğ b	15. Decedent's Education (Specify only highest grade completed) 16a. Dec	cedent's Usual Occupation (Give kir ing most of working life. DO NOT us	nd of work done	16b. Kind of Business/Ir	dustry
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5-0036 iled within 7 Hygiene I other than	du.	8	Homemaker	Name (First, Middle, M	Own I	Iome
15-(filed Il Hyg ed oth		17. Father's Name (First, Middle, Last)			ŕ	
2121 ould be fil Mental I marked ic event,	o Be	Harvey R. Poore 19a. Informant's Name/Relationship (Type, Print) 19b. N	Mailing Address (Street and Number	Betty Baile er or Rural Route Numl		Zip Code)
MD Ad 2 shot alth and am 27 is aumatic			4 Spangler Way,			
e, P I and Health item		20a. Method of Disposition 20b. Place of D	Disposition (Name of cemetery, or other place)	Date	20c. Location - City or	Town, State
nor ages ant of at: If		Durial 2 21 Cremation 5 Removal from State		08/20/2007	Baltimore,	Maryland
Baltimore, pernit Pages I an Department of Hea Important: If itee	•		22. Name and Address of Facility			
m Fg Fi		- Mal	9705 Belair Rd.,	, Nottingha	m, Maryland	1 21236
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line.	nter the mode of dying, such as can	diac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a Blunt Force Injuries to the hea	d	1		Death
		or condition resulting in death) Due to (or as a consequence of):				
	P	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	C. (Disease or injury that initiated				
ed nsit	Exa	events resulting in death) Last Due to (or as a consequence of):				
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eath certiff	sician	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Pregnant at time of death 5		oregnancy	Month D	ay Year
Box 687 e death certification the attending ed for use as t	ysic	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
Ç. ♣ Ş. Ş.	/ Phy	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part	I. 23e. Did to	bacco use contribute to	the cause of death?
PO ires that the signed by	d b			1 Yes	2 ✔ No 3 Prob	ably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be a base of the control of the cont	Completed			24a. Was a autops		topsy findings available ompletion of cause of
eco he law te has	m C			perfor	med? death?	s 2 No
Vital Reco ysician: The law his certificate has director, page 2 s	Č	25. Was case referred to medical	26.Place of Death (C	Check only one)		
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Division pital or Attend ours after death teral Director:	ertification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	n, street, factory, office building, etc.		treet and Number or Ru late) Harper way, Baltimor	
Division To the Hospital or Attent within 24 hours after death To the Finneral Director:	Çe	determined (Specify) Local Street 29a. Certifier - Cartificing Physicians To the best of my knowledge doubt				
To the Hos within 24 h To the Fun completely	cal	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or investigation.	occurred at the time, date and place estigation, in my opinion, death occi	e, and due to the causeured at the time, date a	e(s) and manner as state and place, and due to th	ed. e cause(s)
To t With Com	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	
	-	701-101-1	O.C.M.E.		August 18, 2007	
7		30. Name and address of person who completed cause of death (Item 23a)			L	
4			Penn Street, Baltimore, M	D 21201		
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1			
Regist	rar	AUG 2 2 2007	Good			
DHMH 17 Rev 1/20	001	ORIC	INAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Edna B. Chew 08/21/2007 2:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Renaissance Catonsville Baltimore 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Date of Birth 6. Sex 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 03/13/1926 1 ☐ M 2 🔀 F 220-12-5495 81 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int. If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location la or 28a-f show t be notified at 10a State 10b. County 10d. Inside City Limits Baltimore MD Catonsville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 711 Maiden Choice Lane PV619 21228 "natural", or items 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2X No Specify. þ 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than Elementary/Secondary (0-12) College (1-4or 5+) 10 Supervisor State Government item 27 is marked other other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å Lloyd L. Lewis Rose Horn ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any Injury or other trau Beverly A. Chew (Daughter) 11 North Merrick Avenue, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Gardens 08/24/2007 Marriottsville, MD. 22. Name and Address of Facility 21. Ignuur f Funeral Service License Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): , avonce if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine sician and burial-trans Due to (or as a consequence of): physician the ası attending properties as IF FEMALE use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical **Examiner**

The law requires that the death certificate be executed

or Attending Physician:

To the Hospital

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funeral director,

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After this

after death

within 24 hours at To the Funeral D filled

Division or Vital Records, P.O. Box 68760 %

altimore, Maryland 21215-0036

Completed by Be ဥ Medical Certification:

2☐ No 3☐ Probably 4☐ Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V Jun M

3a) (Type, Print)

Nachen Curre Curre, Calgurille.

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ohn G. Co	ok, 4		State of Maryland / Department of I-For State Certificate of Registrar		ygiene Reg.	No. 2.0	17 2:22
Phy Nedical Ex	/sicia	an/	1. Decedent's Name (First, Middle,Last)		2. Date of Oeath Month D August 14, 2	Day Year	3. Time of Oeath 0000 hrs
()	· ·		John G. Cook, 4th 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Oeat	h
			Rt. 40 W at N. Fulton Avenue	Baltimore		N/A	
Fun Dire		- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 214-17-3202 1 Am 2 F 25 Yrs	Months Oays Hours Mir	1.	MM/00/YYYY) 9. Bi Forei	
		ŀ	214-17-3202 1 XM 2 F 25 Yrs Usual Residence of Oecedent		\$1/26/1	1982	· Md
	v any		10a. State 10b. County 10c. City, Town or Locat	ion			10d. Inside City Limits 1 X X Yes 2 No
/land	-f sho	į	Md. N/A Baltimore	10f. Zip Code	100	. Citizen of What Cou	
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215- e filed tal Hyg	narked other than "natural", event, the Medical Examiner	Be C	John G. Cook, III	Patrici		iden damane)	
CV 3 C		٩	19a. Informant's Name/Relationship (Type, Print)	g Address (Street and Number or	Rural Route Number		
, MC and 2 sl ealth ar	tant: If Iten 27 is no or other traumatic			yndhurst St.,		ore, Md. 2 20c. Location - City o	
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altin mit. P. partine	portan ury or		4 Donation 5 Other Specify: Arbutus 2 Spature of Fun ral S Specify: 22.1	Name and Address of Facility	Funoral	Homo I	on Ma.
	Sec.	118	Sa. Part I. E ter the diet stat, or complications ty Laused the death. Do not enter to	Name and Address of Facility Step Brothers BOO Eutaw Place	e Balti	more Md	21217 Approximate Interval
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Records, P.O. Box 68760, The law requires that the death certificate be executed	ng phys is the bi	n/Me	23b. Was decedent pregnant in the	etal death 3 Ectopic pregr	ancy	23d. Oate of delive Month	ery Day Year
OX 6	attending phy for use as the	Physician/N	past 12 months? 4 Pregnant at time of death 5 0	ther (Specify)			
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Division tal or Attendii rs after death.	neral Director: After this certification filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	eet, factory, office building, etc.			Rural Route Number, City N. Fulton Ave.
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To the F within 2	To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	ation, in my opinion, death occurred	at the time, date ar	nd place, and due to	the cause(s)
F 3	F 2	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (M	_
\	,]		MAN	O.C.M.E.		August 15, 200	,
bros	X-		30. Name and Address of purson who complete cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Per	nn Street, Baltimore, MD 2	1201		
- Do	S	ate	31. Oate filed (Montr Day, Year) AUG 2 2 2007 32 Registrar's Signature	W .			

			1 = For State Registrar		Marylan		artment of H rtificate of L		, ,	liene	37	26	23
	Physic	an	Decedent's Name (First, Middle, L	ast)					2. Date of Dea Month	Day	Year		of Death
	/Medi	cal	Dora		L.		Campi		8	1	2007	/,	9. M
	Examir	ner	4a. Facility Name <i>(If not institution, g</i> Manor Car			na	4b. City, Town, or	Location of Deat Spring	n	4c. County			
	Funeral				7. Age (In yrs. I		If Under 1 Year	If Under 24 Hrs	8. Date of Birth		ntgom		a or Foreign
	Director		230-07-8190	1 ☐ M 243 F	86	Yrs.	Months Days	Hours Min.	8. Date of Birth Jan Day	Ĭ921		ginia	e or Foreign
	p ,		Usual Residence of Decedent								V. 1.1	311116	1
	anyla shov	2	10a. State 10b. County	George's	10c. City	, Town or Lo	le1phi				10		City Limits
	the M 28a-1	ecto	Maryland Fillice 10e. Street and Number	0001 60 5		AC			1.				as 2 🙀 No
	with w	Funeral Director	1912 Erie Stree	+ # 103			10f. Zip Code	0783	1	0g. Citizen of V		-	
	death	era	11. Marital Status	12. Was Deced	dent Ever in U.S	S. 13.			pecify Yes or No-	14 Bac	U.S.		
9	after or item	Fu	1 Never Married 2 Married	Armed Ford	2 [X] 1 No	1	Was Decedent of His If Yes, specify Cubar		o Rican, etc.)		k, White,		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or items 23a or 28a-1 show ont, the Modical Examinar must be notified at	d by	3 ₩idowed 4 □ Divorced	If Yes, Give Year or Da	tes:		1 ☐ Yes 2 ☐ No	Specify:		Specify	· WI	nite	
5	"natu	Completed	15. Decedent's l (Specify only highest g	Education rade completed)		16a. Dece (Give	dent's Usual Occupa kind of work done d DO NOT use retired)	ition uring most of wor	king	16b. Kind of Bu	siness/Ind	ustry	
12	withir ene. then	mp	Elementary/Secondary (0-12)	College (1-	4or 5+)								
d 2	filed Hygir ther ant, t		6th 17. Father's Name (First, Middle, Las	it)			Homemaker		ne (First, Middle, M	Home	(A)		
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Man	To Be	Charles Pyro	on				_	Compton		-,		
ary	shou and N s mar umat	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street a			City or Town,	State, Zip	Code)	
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event. Ite Medical Examinar must be notified at		Stephen Campi	(Son)		471	0 St. Mar	y's Stre	et # 9 B	eltsvil	1e, N	ID 20	715
Baltimore,	of He		20a. Method of Disposition 1 → Burial 2 □ Cremation 3	Bemoval from S		ace of Dispo	sition (Name of matory or other place			20c. Location -			
Ē	Pages ment of I tant: If its jury or o		'4 □ Donation 5 □ Other (Spec		Man	ryland	Veterans	Cem.	2007	Chelten	ham.	Mary	land
39	permit. Pages Department of Important: If i any injury or one		21. Signature of Funeral Service Lice	n (99)	1.	22	. Name and Address	s of Facility $L\epsilon$	e Funera	1 Home,	Inc.		
	40260		23a. Part1. Enter the disease, or con	alla	110015	3 6	633 Old A	lexandri	a Ferry	Road C1	intor		
П			shock, or heart failure. List only	y one cause on ea	ch line.							Approxima Interval Ba Onset and	etween
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
	Examiner		- 1		mul C								
		ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events c.								-		
· A	acuted Ind transi	aml											
,8760,	death certificate be executed e attending physician and od for use as the burial-transit	E	Due to (or as a consequence of):										
87	physi the t	dlcal		d							1	-	
9 xo	death certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outco	me of pregnar	ncv				224 8-4			
ă	death a atter d for u	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣ No	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year						
P.0	that the de ed by the detached	hys	9 Unknown	9□ Unknov	vn								
	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions	contributing to dea	th but not resul	lting in the ur	nderlying cause giver	n in Part I.	23e. Did tob	acco use contr	ibute to the	cause of	death?
ord	w require been si should I	ted	anemia	osteo	poros	75	Cache	X19_	1 ☐ Ye	s 2000	3 🗌 Proba	bly 4	Unknown
Records	aw is b	Completed	hs of a	empre.	ssion	-fx	T111	2/	24a. Was ar autopsy		Vere autop	sy finding:	s available
_	Th ate pag	Con	hypothe	roidi	5/2			,	perform	1qd? ∕ d	eath?	□ No	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other	. /	th (Check only one				
of	Phys r this aral di	. To	1 ☐ Yes 2√XNo 27. Man or of Death	1 Ing	ome 5 Reside								
O	tending Ph feath. tor: After th the funeral	atlor	1 Natural 5 Pending (Month, Day Year) Injury Work?								urred		
Division of	Atter ar dea ector by the	ifica									on (Street and Number or Rural Route Number,		
	safter sal Dire	Description building, etc. '(Specify) City or Town, State) 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as and manner stated. City or Town, State) City or Town, State)											
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral										nner as sta nd due to	ted. he cause((s)
	To th withir To th comp	Me	29b. Signature and title of certifier	0	11		29c. License			ld. Date signed		ay, Year)	
)			1 mil	rul	14.	W.	D 00 S	5362	- (8-21	-07		
	Ð		30. Name and address of person who 31. Date filed (Month, Day, Year)	completed cause	of death (Item.)	23а) (Туре. 1	Pipil Keis	che Len	anent Mi	201	Sag 050	1 k	14cos
	Sta Registr	te ar	31. Date filed (Month, Day, Year) ÄUG 2 2 2	007 32 Reg	gistrar's Signati	ILE OF	west .			- 4			

07-06389

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Bradley James (ıllo 1- For State	State of M	1aryland		artment of			Menta	l Hy	giene	3.2.0.	90	17 2582
Physicia		Registrar 1. Decedent's Name (First,	Middle Last)		Cei	uncate of	Deal	.77		12	R. Date of Dea	eg. No.		3. Time of Death
Medical Exami		Bradley	James	Caru1	1 o					- 1	Month August 18	Day Y	'ear	0332 hrs
		4a. Facility Name (if not instead 9102 Abigail Drive		et and number	1	4	b. City,	Town, or Lo	ocation of I			4c. Coun	y of Deat ore Co	
Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. I	ast birthday)		ler 1 Year	If Under 2	24Hrs.	8. Date of Bir			rthplace (State or
Director		213-13-8340	1 X M	2 F	30	Yrs.	Monti	ns Days	Hours	Min.		1976	Forei	
8		Usual Residence of Decede										., 23,0		
ow any		10a. State 10b. Co			10c. City,	Town or Locati								10d. Inside City Limits 1 Yes 2 X No
de:yland 28a-f show 3 at once.	ctor	Maryland 10e, Street and Number	Baltimo	re			C (ckey	svill	e.	14	0g. Citizen of	Mhat Car	
th the Maryland 23a or 28a-f sho	Director	200 Cranbro	ok Road				101. 21	210	20					
with t		11. Marital Status	12. V	Vas Decedent		.S. 13. Wa	s Deced	ent of Hispa	anic Origin	? (Spe	cify Yes or No)- 14. Ra		A . rican Indian, Black,
death or ite	Funeral	1 X Never Married 2	1		X No	If Yo	es, speci	ify Cuban, I	Mexican, P	uerto R	ican, etc.)	- Wi	nite, etc,	
rs after ural", miner	þ	3 Widowed 4 15. Decedent's Education	Divorced If Yes, or Dat	es.	anloted)	16a. Decedent		X No			al. alama (Specif		White
72 hou	eted	Elementary/Secondary (0		ollege (1-4 or				rking life. E				TOD. KING OF	business	industry .
036	Completed	11				Ge	nera	al Mar	nager		1	Hospi	tali	ty Industry
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Mi		_				18				Maiden Surnar	ne)	
212' wild be Mental marke	To Be	Stephen Jame 19a. Informant's Name/Rela				19h Mailing	Addres	S (Street :				nn Ree mber, City or T		o Zin Codo)
MD do 2 short lith and n 27 is aumatic		Jennifer Ly		•	ther)							Maryla		
t te le a co		20a. Method of Disposition 1 Burial 2 X Crem				Place of Disposi crematory or oth	tion (Na	me of ceme			Date			r Town, State
Pages nent of ant: I or oth		4 Donation 5 Oth		moval from St	ale	yview C:	rema	tory	0	8/24	4/2007	Balti	nore.	Maryland
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr	ı	21. Signature of Funeral Se				22. N	ame and	Address o	of Facility	Schi	imunek	Funera	1 Ho	me Inc.
Physician		23a. Part I. Enter the disease	or complication	LLL:	the death	97	05 E	Belain	r Road	d, N	Notting	gham, M	ary1	and 21236 Approximate Interval
/Medical		failure. List only one c	iuse on each line	١.		nd of right ea			oon as care	nac or r	espiratory arr	est, shock, or	leait	Between Onset and Death
Examiner		Immediate Cause (Final dis or condition resulting in dea		(or as a cons			and	nead		_				
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b	(or as a cons	equence o	f)·			_					
	Examiner	cause. Enter Underlying Ca (Disease or injury that initia	use ed c		-									
ecuted and transit		events resulting in death) L	ast Due to d.	(or as a cons	equence o	f):								
exe	edical	UNPENDED	AME	NDED						-				
Box 68760, e death certificate be the attending physicied for use as the burned for use		IF FEMALE: 23b. Was decedent pregnan	in the	. If yes, outcor	ne of preg		_1 _141_	2	Ectopic pr			23d. Date		•
x 68 th certi ttendin r use a	sician/M	past 12 months?	4	Pregnant at	time of de	oth -	al death ner <i>(</i> Spe		_Ectopic pi	egnand	-у	Month		Day Year
). Bo the dea by the a	Phys	1 Yes 2 No 9 Part II. Other significant co	9	Unknown							Too sill			
Division of Vital Records, P.O. B rat or Attending Physician: The law requires that the d irs after death. at Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached	ρ	Tartii. Other significant co	nduons contin	buting to deat	1 But not re	esulting in the u	naeriying	g cause giv	ren in Parti					the cause of death? bably 4 Unknown
rds requir	Completed										24a. Was			utopsy findings available completion of cause of
Recol The law icate has page 2 sl	ошо								-		perfo	rmed?	death?	es 2 No
tal Rection: The certificate	Be C	25. Was case referred to me examiner?							f Death (Cl	neck on				
of Vit	2	1 ✓ Yes 2 No	Hospita	i III III patie		ER/Outpatient						Residence 6		er: Scene
on on or or or or or or or or or or or or or		27. Manner of Death 1 Natural 5	Pending F	ia. Date of Inju (Month, Day,Y OUND:	ear)	28b. Time of Ir FOUND:	ijury	28c. Injury	at Work? s 2 ✔ No	ls.	8d. Describe I unject sho	how injury occi it self	urred	
IVISIOR or Attend after death. Director:	ficat	2 Accident	nvestigation A	ug 18, 2007 Be. Place of In	-	0324 hrs ome, farm, stree	t, factory				8f. Location (Street and Nur	nber or R	ural Route Number, City
Divis Hospital or A 24 hours after Funeral Dire	Certification:		Jould not be	Specify) Mu					3.		or Town, S	State)		
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	4 Homicide (Specify) Multi-Family Apt. 9102 Abigail Drive, #2C, Rosedale, MD 29a. Certifier (Check only) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month 6													
F # F S	ž	29b. Signature and title of ce					29	c. License r		DCME				onth, Day, Year)
		Theolin	M. T.	- V	RU	un		O.C.M	.E. '	JUNE		August 1	8, 2007 —	<u></u>
T 5	ſ	30. Manfe and address of pe Theodore M. King,		ted cals of d			111 P	enn Stre	et Baltir	nore	MD 21201	1		
St	ate	31. Date filed (Morn) PR. Y	90)0 2007	32. Registra	r's Signatu		- I E		or, Daruf	noie,	1VID 2 12U	· · · · · · · · · · · · · · · · · · ·		
Regist		MUG	2 7001	A Contract	is &	J. LIVE	ale de							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** 19, /Medical Mary C. Cassett August 2007 1:10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F Director 213-40-1161 66 6/8/41 Maryland Usual Residence of Decedent a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Baltimore Bradshaw 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ir than "natural", or items 23a the Medical Examiner must b USA 21087 permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Fyaminas must Funeral 8038 Bradshaw Road Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: ð Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Joseph I. Streett Elizabeth Frank 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8038 Bradshaw Road Bradshaw, Maryland 21087 Mr. Ronald B. Cassett, Sr. 20a. Method of Disposition 20b. Place of Disposition (Name of Badenerory 20c. Location - City or Town, State 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) @ Loudon Park 8/20/07 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or has it failure. List only one cause on each line. Approximate Interval Pote Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 7 Physician tan 9 /Medical Due to (or as a consequence of) Examiner be CM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1☐ Yes 2☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a a□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s certificate has performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 No 1 🗀 Inpatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Certification: 28c. Injury at Work? To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1-Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Medical 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) N. Clarles St. State Registrar

07-06413

Darius Cox	1- For State Registrar	yland / Department o <i>Certificate o</i>		ygiene Reg. I	No.	7 1 1
Physician/	Decedent's Name (First, Middle,Last)	· · · · ·		Date of Death Month Date	av Year	3. Time of Death
Medical Examiner	4a. Facility Name (if not institution, give street an	DX	4b. City, Town, or Location of Death	August 18, 2	007 4c. County of Death	2345 hrs
	University Hospital Shock Trauma	. Hembery	Baltimore	Process of the second	AU. County of Death	A
Funeral	Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs		MM/DD/YYYY) 9. Birt	
Director	218-27-802/ 15M 2	F 17 Yrs	Months Days Hours Mir	Feb. 3,	1990 Foreign	intry) Maryland
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loca	ition			10d. Inside City Limits
*	Marsland NJA	,	Battino	e		1 Yes 2 No
hours after death with the Maryland natural", or items 23a or 28a-f show Examiner must be notified at once. ed by Funeral Director	10e. Street and Number	<u></u>	10f. Zip Code	. 10g.	Citizen of What Coun	ry?
ith the 23a or notifie	443 N. Curley	71.	21224		W	<u> </u>
or death with or items 23 must be no Funeral	1 Never Married 2 Married Arme	d Forces?	as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	can Indian, Black,
s after d rial", or niner m	3 Widowed 4 Divorced If Yes, Give		Yes 2 No specify:		Specify: Bla	ck
hours natur Exam	15. Decedent's Education (Specify only highest	during m	nt's Usual Occupation (Give kind of nost of working life. DO NOT use ret		6b. Kind of Business/Ir	ndustry
5-0036 ed within 72 hour lygiene thau "natu the Medical Exan Completed	Elementary/Secondary (0-12) Colleg	e (1-4 or 5+)	Hudent	2011	MIA	
	17. Eather's Name (First, Middle, Last)			e (First, Middle, Maid		
2121 Muld be fil Mental J marked c event,	Darius Co X 19a. Informant's Name/Relationship (Type, Print	Lans Mairie		al Sim		
MD 21 d 2 should th and Me th and Me a 27 is ma umatic ev	Dessarae Simmons-	nother 44	ng Address (Street and Number or	ST. Ba	r, City or Town, State,	Zip Code) 21224
. 4 5 5 5	20a. Method of Disposition	20b. Place of Dispos	sition (Name of cemetery,	Date 20	0c. Location - City of	Town, State
Baltimore bermit. Pages 1 a Department of H Important: It in injury or other t	4 Donation 5 Other Specify:	al from State	1em. Park 8	2407 A	Randalls+	own, Md.
Balt permit. Departi Import	21. Signature of Fundal Service License	Un 22.1	Name and Address of Facility	KerFyr	eral Hon	4 PAina
Physician	23a. Part I. Enter the isease, or complications the failure. List only one cause on each line.	at caused the death. Do not enter t	the mode of dying, such as cardiac	or respiratory arrest,	shock, or hear	Approximate Interval
/Medical Examiner	Immediate Cause (Final disease a. gunshot	wound of back	18.75			Between Onset and Death
		as a consequence of):	100	5190		
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	as a consequence of):				
ted Insit Examiner	(Disease or injury that initiated C	as a consequence of):				
50, te be executed sysician and burial - transit	d					
50, te be executed ysician and burial - transi	UNPENDED AMENDI					
1876 tificate ing phy as the		es, outcome of pregnancy /e birth 2 Fe	etal death 3 Ectopic pregna	ancy	23d. Date of delivery Month D	ay Year
). Box 68760, the death certificate by the attending physical for use as the burnel Physician/Mec	1 You 2 No 0 Unknown 4 Pi	egnant at time of death 5 0	ther (Specify)			
P.O. Box that the death ned by the atte detached for u		known g to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
ords, P.O. w requires that the state of the			, , ,	1 Yes 2	2 No 3 Prob	ably 4 🗸 Unknown
Records, P.(The law requires that ficate has been signed; page 2 should be determined.				24a. Was an autopsy		opsy findings available ompletion of cause of
tal Reco				performe 1 ✓ Yes 2	d? death? No 1 ✓ Yes	
Vital Rec ystcian: The his certificate director, page	25. Was case referred to medical examiner?		26.Place of Death (Check			
of Viring Physical After this vaneral dir	1 ✓ Yes 2 No	Inpatient 2 ✓ ER/Outpatient ate of Injury 28b. Time of		ng Home 5 Res	sidence 6 Other:	
Division of Vital Records, spiral or Attending Physician: The law requirement Director: After this certificate has been sineral Director: After this certificate has been selected by the funeral director, page 2 should Certification: To Be Completed	1 Natural 5 Pending Aug	onth, Day Year) 18, 2007 2304 hrs	1 Yes 2 No	Subject shot	injury occurred	
visic or Atte frer der Directo in by th	2 Accident Investigation 3 Suicide 6 Could not be 28e. F	 rlace of Injury - At home, farm, stre	et, factory, office building, etc.			al Route Number, City
Divi	4 Homicide determined (Spec	ify) Sidewalk		or Town, State 2400 block of Wo	e) oodbrook Avenue, I	Baltimore, MD
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending by Completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/I/Medical Certification:	29a. Certifier 1 Certifying Physician: To the one) 2 Medical Examiner: On the ba		rred at the time, date and place, and tion, in my opinion, death occurred a	. ,		
To with	and mann 29b. Signature and title of certifier		29c. License number		d. Date signed (Mon	
	The 11 V:	4 7	O.C.M.E.	CME	ugust 19, 2007	
6	3. Nime and address of person who cimpleted					
State		stant Medical Examiner Registrar's Signature	111 Penn Street, Baltimor	e, MD 21201		
State Registrar		Registrar's Signature	w			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month &31 AM 2007 Ĺ /Medical and number) Sity, Town. Facility Name (If not institution, give street or Location of Death 4c. County of Death Examiner DECOUL 8. Date of Birth (Month, Day, Year) ocial Security Number birthdav nder 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. Yrs. 83 Director 08 31 231**-**22**-**1304 VA Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at X☐Yes 2☐No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be 21217 23a 1901 Elgin Ave Apt 203 U.S.A. death v Funeral 14. Race - American Indian, or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 'natural'', or iten dical Examiner Black, White, etc. should be filed within 72 hours after on Mental Hygiene. marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ģ Specify: 3 Widowed 4 Divorced Black Be Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Morgan State Elementary/Secondary (0-12) College (1-4or 5+) 12th grade na Head Cashier University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F James G. Perkinson ျှ Adelaide Venable 19a. Informant's Name/Relationship (Type. Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia Inell Johnson 1901 Elgin Ave Apt 303, Baltimore, Md 21217 27 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 -1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Injury or Department of Important: If any Injury or once. Donation 5 Other (Specify) King Memorial Park 8/22/07 Randallstown, 21 Signature of Funeral Service Licensee March F/H West Part Enter the disease, or compile the ns that caused the shock, or heart failure. List only one calls are neach line. 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death de ath. Do at enter the mode of dying, such as cardiac or respiratory arrest, Inmediate Cause (Final lisease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760. physician Physician/Medical the use as I ed by the attending I detached for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mon Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown cate has been signed by page 2 should be detach Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ş 1 □ Yes 2 □ No 3 T Probably 4 Junknown Be Completed 24a. Was an . Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? certificate 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 Di Netural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No Hospital or Attendi 4 hours after death. Funeral Director: A ely filled in by the fu death. 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29b. Signature 29c. License number itle of certific 29d. Date signed (Month, Day, Year,

Registrar

State

Date filed (Month, Day,

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	Physici	an	1. Decedent's Name (First, Middle, La					2. Date o		Day Year	3. Time of Death	
	/Medi		Mary L. Fl					Aug.	18		4:15a ^M	
	Examir	ner	4a. Facility Name (If not institution, give	e street and number)		4b. Cit	ty, Tow n , or	Location of	f Death	4	c. County of Death	
11 m 7 m 4 m	ok over kle) de		49 Nunnery Lane				atons				Baltimore	
	uneral irector		053-28-649/	ex 7. Age	(In yrs. last birtl	rs. Month		If Under 2 Hours	8. Date of (Month) 9 – 7	Birth Day Yes -1935	(Ir) Cou	place (State or Foreign ntry) W York
and	A 41		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
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thin 7	an "r Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of v life. DO NOT	use retired))	or working			
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בַּ בַּ	d oth	Be (17. Father's Name (First, Middle, Last)				- 1	18. Mother	r's Name (First, Mic	idle, Maid	en Surname)	
ould b	arkec artic e	2	George Binder					E1sa	Hempe1			
Sho	is is		19a. Informant's Name/Relationship (I						or Town, State, Zip	, Zip Code)
and	er tra		John C. Flinton,	husband	49	Nunner	cy Lar	ie, Ca	atonsvill	e, Md	. 21228	
- F - C	roth		20a. Method of Disposition	Demonstra Otata	20b. Place of l	Disposition (A	lame of r other plac	e)	Date	20c.	Location - City or To	own, State
Page	T. T.		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Metro		•	í i	8/21/07	Car	tonsville	. Md.
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j § §	Important in any ir		Iranda Z	Lemm	er	of Ca	tonsv:	$\frac{111e}{2122}$	8 Inc. 163	0 Ed	mondson A	Witzke FH ve., Catons
Phy	/sician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line		ot enter the m	ode of dying	g, such as c	cardiac or respirato			Approximate Interval Between Onset and Death
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the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death	signed by the attending be detached for use	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of Month Mont								23d. Date of delive Month	ery Day Year
that t	ed by		Part II. Other significant conditions of	the underlying	cause give	en in Part I.	23e. D	Did tobacco use contribute to the cause of death?				
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9 <u>a</u>		ld L							24a. V	utopsy	24b. Were auto	psy findings available mpletion of cause of
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ician	r this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			Other		of Death (Check or			
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Bull	After	on	27. Manner of Death 1 ■ Natural 5 ■ Pending	me of ury	28c. Injury Work			d. Describe how injury occurred				
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or At	n by	Certification:	3 Suicide 4 Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)								and Number or Rura ite)	d Route Number,
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0	Y	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									0000	
8			Jucadkiv W	VO 1120	N. Rell	in 2.	1 Cai	tusvi	ille me	2	1228	
	Sta	te	31. Date filed (Month, Day, Year)	. Registrar	's Signature	P						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FARMER AMISON 05:05 M HUGUST 20 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 225-60-1834 63 1944 North Carolina Director Usual Besidence of Decedent 10c. City, Town or Location wouls ! 10d. Inside City Limits r 28a-f shov notified at 1 □Yes 2 📈 炊o Director Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medic | Examiner must be r 308 Hopkins Road 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **27.** No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes XX No Specify. þ 3 ☐ Widowed XX Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Education marked other Ith and Mental Hve traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Grigsby Holdren Sr Libby Jamison 19a. Informant's Name/Relationship (Type. Print) Evan R Farmer Jr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any injury or other trau Son 308 Hopkins Road Baltimore, Maryland 21212 20a. Method of Disposition 1 ☐ Burial 2 🛣 remation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages ' □Donation 5 □ Other (Specify) Green Mount Crematory 8/22/07 Baltimore, Maryland ignature of Funeral Service License 22. Name and Address of Facility MITCHELL-WIE GETELL Funeral Forme Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MONAVU /Medical Due to (or as a consequ Examiner Varian Sequentially list conditions, Examiner Tue to for as a consequence off if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) Physician/Medical as the IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy perform 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

that the death certificate be executed Box 68760, Division or Vital Records, P.O. ne Hospital or Attending P n 24 hours after death. he Funeral Director; After t

within 72 hours after

Baltimore, Maryland 21215-0036

completely filled in by the within 2

State Registrar (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOCK, THE JOHNS HOPKINS HOSPITAL, 600 N Wolfest, Baltmare, MD 21287 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10b, perFH, 24a, 28b, perMF, 9870, 8722/07 TI
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Robert L. Fronckoski, 2. Date of Death 3. Time of Death Day **Physician** Jr. Month Year 11:12 AM 8 Z007 /Medical 6 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Baltone Mary lan 0 If Under 1 Year If Under 24 Hrs. Social Security Number 219–62–6311 6. Sex Date of Birth (Month, Day, Yea 4/3/1954 Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 53 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Arundel Linthicum Heights Director Anne Arundel 1 ☐ Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 6426 St. Phillips Road 21090 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2K Married 1 ☐ Yes 2000No Specify: Completed by Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Longshoreman 12 Shipping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert L. Fronckoski, Sr. Joan Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6426 St Phillips Rd, Linthicum Heights MD 21090 19a. Informant's Name/Relationship (Type, Print) Donn L. Fronckoski/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 08/20/2007 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 ichature of Puneral Service Licensee Victor P. Doda, Jr. 1,0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tracture with bilderal vertebral /Medical Due to (or as a consequence of): **Examiner** Maritarion Principal By Report Expuns Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 1 pnpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred "unk. Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☑ No 2 Accident 8/12/2007 Body surting 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of ural Route Number, City or Town, State) 4 Homicide Cito Ocean 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 18239 Critical Care Fellow 8/16/2007 n who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Mayor - Naryan 54 Baltimore. 32. Registrar's Signatur 31. Date filed (Month Day, Year) State 2007 2 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Margaret Codu

4a. Facility Name (If not institution, give street and number) Godwin /Medical August 21 2007 10:30 A 4b. City. Town, or Location of Death 4c. County of Death Examiner Catonsville Commons Nursing Home Catonsville Baltimore 8. Date of Birth (Month, Day, Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months Oct. Director 214-22-5963 1911 95 Maryland Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Florida Palm Beach Palm Beach 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death v 330 Cocoanut Row 33480 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify \$ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12 should be filed whand Mental Hygies Is marked other the Office Clerk Finance traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked c any injury or other trauments. John Phillips Marguerite Kunnert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Goldstein Granddaughter 330 Cocoanut Row; Palm Beach, Florida 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lorraine Park 8/24/2007 Woodlawn, Maryland 22. Name and Address of Facility Sterling Ashton S Funeral Home of Catonsville, Inc. 21. Signature of Full eral Service Licen Ashton Schwab Witzke 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician to thrive Tailure Mas /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed Examir burial-trar Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9☐Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Cance 2☐No 3☐ Probably 4☐Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed' certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending 24 hours after death. 1. Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1120 N. Relling Reed Cotnone mo 21228 Meek W 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 2 Registrar

DHMH 17 Rev 1/2001

			State of Maryland / State of Maryland / Registrar	-	artment o			ind M		giene Reg. No. &	007	
16	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of Dea Month	Day	Year	3. Time of Death
	/Media	cal	Lawrence E Gibbons							18	07	9:50 P. M
	Examir	ier	4a. Facility Name (If not institution, give street and number)								unty of Death timore (
	Funeral		GOOD SANARITAN HOSPITAL BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.									-
- 8	Director		216 30 5067 1 N 2 F 73	Yrs.			Hours	Min.	8. Date of Birth (Month, Day August 2	v, Year)	South	nplace (State or Foreign Intry) Fork, PA
	p. ,		Usual Residence of Decedent						145000 2		Land	
	anylau show	Ä	10a. State 10b. County 10c. City, Tow	wn or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the Marylar 28a-f show notified at	Director	Maryland Baltimore Perry H	bll_	T405 75- 0-	d c				4000		X
	with a or	ä	4201 Likens Road		10f. Zip Coo					_	of What Cou	intry?
	ns 23a must b	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	13. V			panic Orig	in? (Spe	ecify Yes or No- Rican, etc.)	USA 14.	Race - Amer	ican Indian,
9	after or ite		Armed Forces? 1 □ Never Married 3 Married Armed Forces? 1 □ Never Married 3 Married If Yes, Give					Puerto	Ričan, etc.)		Black, White	, etc.
933	172 hours after dea "natural", or items edical Examiner mo	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	'	l∐Yes 2∭g	đло	Specify:			Sp	^{pecify:} Whi	te
21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed)	a. Deced	lent's Usual Oo kind of work do OO NOT use re	ccupati one dui	ion ring most	of worki	ng [16b. Kind	of Business/I	ndustry
121	withir ene. than he Me	E D	Elementary/Secondary (0-12) College (1-4or 5+)		Splicer T					D-11 /	. نــــ تـــ	
	filed Hygi other ent, tl		12 N/A Cal 17. Father's Name (<i>First, Middle, Last</i>)	DIE 3	pricer i				(First, Middle,		Atlantic rname)	<u> </u>
an	lid be fental rked c	o Be	Lawrence Gibbons				Jennie				ŕ	
Maryland	s 1 and 2 should be filed w f Health and Mental Hygie item 27 is marked other ti other traumatic event, th	-3		b. Mailin	g Address (Sti	reet an	d Numbe	r or Rura	l Route Numbe	er, City or To	own, State, Z	ip Code)
	5 = 2 :	18						y Hal	<u> 1, Mi. 2</u>	1128		
Baltimore,	ges 1 al it of Hea if item or othe		I La Dullati 2 Li Ciettationi 3 Li neniovali il oni State i		sition (Name o natory or other				ate	20c. Locat	ion - City or T	own, State
ţ	: Pac tment tant:		4 Donation 5 Dother (Specify) Ho⊔y		. Mem. Gd					Baltim	ore, Mar	yland
Bai	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. at ye of Funeral Service Licensee	La	Name and Adassahn Fu	^{ddress}	of Facility LHcm	e Im	2			
		0 0	23a Part 1 Enter the disease of complications that caused the death. Do	74	01 Belai	r Ro	ad such as o	Balti	more, Mar	ryland	21236	Approximate
	Dhysisian		23a. Pan1. Enter the disease of complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final	100			0001700	301 0100 0	i roopiiatory ai	, соц	7	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence	-	umon	12					_	
	Examiner		C dilliele	col	tis	wit	h	ana	carco	٤,		
	P #	ner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	of):			indi.	, , ,				
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ĕ	death atte	icial	in the past 12 months? 1		lEctopic pregna l Other <i>(specif</i>)					200	Month	Day Year
P.O.	t the by the	hys	9 ☐ Unknown									
'n,	gned be de	by P	Part II. Other significant conditions contributing to death but not resulting i	in the un	derlying cause	e given	in Part I.	4	23e. Did to	bacco use	contribute to	the cause of death?
ord	equir sen si ould I		carcinoma of prostate	<u> </u>	ath m	eto	rs ta	Sid	1 🗆 Y	es 2□N	lo 3∏ Pro	bably 4 Unknown
ec	law I	Completed	wagelopathy.						24a. Was a	sy	4b. Were aut	opsy findings available ompletion of cause of
프	: The cate I	Sol							perfor 1⊟ Yes	med? 2 No	death? 1 🗆 Yes	2 □ No
Vit.	sician certifi rector	Be	25. Was case referred to medical examiner?			Other:			(Check only or			
ō	Phys r this ral dii	٠ <u>.</u>	inpatient 2 EH/Oi	utpatient Time of	3 DOA		4 LI Nur		ne 5 Resid			ify)
Division or Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ţi		Injury		Injury a Work? 1 ∐ Ye	es 2∐N		od. Describe II	ow injury of	ouried	
Visi	Atter r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, fa building, etc. (Specify)	arm, stre	et, factory, off	fice	-1000	2	28f. Location (S	treet and N	umber or Rui	al Route Number,
	tal or s afte al Dir ed in	Certification:	Dullding, etc. (Specify)						City or Tow	n, State)		
	Hospi 4 hour Funer ely fill		29a. Certifier (Check only only only only only only only only	je, death	occurred at th	ne time, my opir	, date and	place, a	and due to the d	cause(s) and	d manner as	stated.
	the hin 24	Medical	and manner stated.									
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	1.1	-	Deep Shazin			KES	500	<u> </u>		0/18	510/	
•	511		30. Name and address of person who completed cause of death (Item 23a)	(Type, F		en Q I	to 1	_ 4	los and	a/ n	La Oti.	SEC 110
	Sta	te	31. Date filed (Month, Day, Year) 32. Reputrar's Signature		Samo		1 1	_ (प्रचित्रा ह	4,0	acun	www. No
	Registr	ar	AUG 2 2 2007 Magua St	1	Destil							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #7, perFH,g870,8/20/07 TT Department of Health and Mental Hygiene 1- State Registrar Amend #30, per DVR, C870, 8/22/07 TT Certificate of Death 1. Decedent's Name (First, Middle, La 2. Date of Death 3. Time of Death **Physician** 6:40 AM M /Medical acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Esthers Place Baltimore, Maryland Baltimore Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 □ M 2 🕽 Director 02/16/1917 Pennsylvania Usual Re the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show at 28a-f sh 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 ms 23a or 6000 Kenwood Avenue 21237 U.S.A. death Funeral Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 7 is marked other than "natural", or Iter traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: Completed by Specify: 3 Nidowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F ပ <u>Michael Krevanchi</u> <u>Mary Gazda</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If Item 27 any injury or other tronge. <u>Theresa Dietz</u> 6731 Mount Vista Road - Kingsville, Maryland 21087 (daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 08/22/2007 Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 60 aa 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NQ Man Wa Va /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed burial-tran and Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ been si 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate | perform med? 2XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2) No 1 ☐ Yes Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) e Hospital or Attending P 24 hours after death. e Funeral Director: After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) Ġ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Mohammad Reza Rahnama Esters Place, Baltimore, Day, Year) 32 Registrar's Signature State 2 Registrar

Amend 9,11–12,15–20a,22,perFD,68/0, 8/22/07 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Allan Stuart Goldman /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ounty of Death Cher rince If Under 1 Year | If Under 24 Hrs Social Security Number (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace Funeral Hours Months Days 1952 New York 1**∑**M 2□F 061-40-8707 **Director** 54 17 Sept Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anotes. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director MD 1 ☐ Yes 2 ☑ No Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7730 Emerson Road 20784 USA Funeral unk 12. Was Decedent Ever in U. SINK Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Computer Programmer IRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be Maxwell Goldman Lillian Steingold ၉ 19a Informant's Name/Relationship (Type. Print)
Norman Goldman/ Brother
Prince George's Medeial 19h Mailing Address (Street and Number of Rural Floute Number, City or Town State, Zip Code)
7194 Woodrow Wilson Dr. Los Angeles, CA 9006 3001 Hospital Drive Cheverly, MD 20781 Center 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 08/20/07 4 □ Donation 5 M Oth ooih) in state Alexandria, VA 22. Name and Add ess of Facility Toroghinsky, Hebrew, F.H., 254 Carroll St. NW 21. Signat Funoral 9 TV Director Baltimore, MD 21201 Washington, D.C. 20012 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherose Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) I ☐ Yes 2 ☐ No ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed: 2 🗆 No 1∐ Yes 2 N 1 TYes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only the 29b. Signature and title of certifier 29c, License number 2 29d. Date signed (Month. Dav. Year) Do 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ves Tes evador 304 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

roncki, Josephin

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi

	1 - State Registrar	Reg	Reg. No. 2 (1 1 7 2 5 5 5 5)										
	1. Decedent's Name (First, Middle, Last)				2. Date of Death	Day	Year	3. Time of Death					
an al	Josephine Wanda Groncki				Month	17	27	6:40PM					
er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County							
	Franklin Square Hospi	tal	Kose			Ba	1+11	more					
	5. Social Security Number 6. Sex 7. Age (Inflyrs. Inflyrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear)	9. Birthp	place (State or Foreign						
	217-24-3231 78	Yrs.			Aug. 16	, 1929	Mary	yland					
	Usual Residence of Decedent 10a, State 10b, County 10c, City	, Town or Loc	ation				1	IOd. Inside City Limits					
0	Maryland Baltimore Dun	dalk						1 □Yes 2 No					
rect	10e. Street and Number	IUAIK	10f. Zip Code		100	. Citizen of W	hat Cour	ntry?					
Ö	3415 Court Way		21222			United		,					
era	11 Marital Status 12. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp				can Indian,					
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S	+2	Home	maker			Own Hor							
	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma		e)						
P	Walter Borys				e Jakubov								
	19a. Informant's Name/Relationship (Type. Print)				al Route Number, C	-		Code)					
	Karen Chandler (Daughter) 20a. Method of Disposition 20b. Pl	<u> </u>	Anderson		te Hall,	Md. 21 c. Location - 0		Ctata					
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	emetery, crem	atory or other plac	e) ;			•						
	4 Donation 5 D Other (Specify) HO		ry Cemeto		/2007 Di	ındalk,	Maı	cyland					
	21. Signature of Funeral Serving Ligensee	/ Du	da-Ruck 1	Funeral H	ome of Du								
	23a Part Enter the disease or complications that caused the ceath	Do not ente	22 Wise	Avenue D	undalk, N	Marylar	nd 21	L222 Approximate					
	shock, or heart failure. List only one cause on each line.												
	Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Embolism Due to (or as a consequency of):												
	Lucio (di as a consequenta di).												
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Medical Examiner	Sequentially list conditions, if any leading Limited to cause. Enter Underlying Cause (Disease or Injury that initiated events												
Exa	resulting in death) Last C. Due to (or as a consequ	ence of):			·								
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ple	Congestive heart	fo	allure		24a. Was an autopsy	24b. V	ere auto	psy findings available mpletion of cause of					
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Be (25. Was case referred to medical examiner?				(Check only one)								
P	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient		4 LI Nursing Ho	me 5 Residence			(y)					
ü	27. Manner of Death 1	28b. Time of Injury	28c. Injury Work		28d. Describe how	injury occurre	ed						
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Medical Certification: To Be Completed by Physician/	29a. Certifier 1 ☑ Certifying Physician: To the best of my know	vledne death	occurred at the time	ne date and place	and due to the serv	eo(e) and ma-	nner co	tated					
lica	(Check only one) Check only one Check one Check only one Check on	ion and/or inv	estigation, in my o	pinion, death occur	red at the time, date	se(s) and mar e and place, a	ind due to	tated. the cause(s)					
Mec	29b. Signature and little of certifier		29c. License	number	29d	. Date signed	(Month.	Day, Year)					
	· Carl		001	15177		OI.	01-						
	30. Name and address of person who completed cause of death (item	23a) (Type 5		733171		8/1	810.	<i>†</i>					
	Sebastian John 3023 Fa	stern	Aven	re R	Homer	MO	212	14					
te	31. Date filed (Month, Day, Year) 32. Registrar's Signat	ure	1		7,44		- 100						
ar	AUG 2 2 2007 Marie .	St A	portu										

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 4a per doc 98/0 8-22-07 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Y 5:50 PM Brian waync ... 4a. Facility Name (If not institution, give street and number) Brian Wayne Hoffman 4c. County of Death 4b. City, Town, or Location of Death 2809 Boston St. Baltimore 5. Social Security Number 7. Age (In yrs. last birthday Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 M 2 □ F Months Days December 5,1956 135-56-5568 50 Yrs. Ohio Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1XX es 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2809 Boston St. Apt. 344 21224 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: Specify: White 3 Widowed Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Terminal Manager Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl Hoffman Anna Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Hoffman / Daughter 124½ East Walnut St. Alexandria, VA 22301 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial ★★Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 8/21/07 4 □ Donation 5 □ Other (Specify)

21. Signature of ral Serice License Baltimore, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) oute to the cause of death? B ☐ Probably 4 ☐ Unknown ere autopsy findings available for to completion of cause of eath? Yes 2 No or Rural Route Number,

Physician/Medical þ Completed Be 2 Certification:

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Examiner

Physician

/Medical

Examiner

Director

Funeral

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filed within 72 hours after death with the Marylan Hygiene. And "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at

d 2 should be filed w h and Mental Hygie Is marked other ti

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, i

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within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

To the Hospital or Attending Physician:

death.

attending physician

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

9 ☐ Unknown	9∐Unknown	
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of de 1 ☐ Yes 2♣ No 3 ☐ Probably 4 ☐ Ut
		24a. Was an autopsy performad? 1 Yes 22 No 1 Yes 2 No 1 No 24b. Were autopsy findings a prior to completion of cardeath?
25. Was case referred to medical	26. Place of Death (C	Check only one)
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence 6 □Other (Specify)
27, Manner of Death 1	(Month, Day Year) Injury Work? n M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or Rural Route Numb City or Town, State)
29a. Certifier (Check only check only check only 2 Medical Example 1	nysician: To the best of my knowledge, death occurred at the time, date and place, and miner: On the basis of examination and/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)

2

THY 600 31. Date filed (Month, Day, Year)

29b. Signature and

N. Work 57 32. Registrar's Signature

and manner stated

s of person who completed cause of death (Item 23a) (Type, Print)

Baltimete MI)

29d. Date signed (Month, Day, Year)

State Registrar

29c. License number

07-05990

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Mandand / Department of Health and Mental Hydiene

lonzo Avery Ha			of Maryland / Dep	artment of He ertificate of De	aith and Mental		1 to	41 64 5
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death wi	Funeral	1 X Never Married 2 Married	Armed Forces? 1 Yes 2 X No				/	2/00/
fter d			If Yes, Give Year or Dates:	1 Yes	2 X No specify:	140	Specify: Sb. Kind of Busines	e/Industry
ours a	d by	15. Decedent's Education (Specify or	nly highest grade completed)	16a. Decedent's U	sual Occupation (Give kind f working life. DO NOT use		D. Killa of busines	Sylliddetry
72 hg	efe	Elementary/Secondary (0-12)	College (1-4 or 5+)				1/10	7
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Completed	121	NIA	une	MPIOYED 18.Mother's N	Name (First, Middle, Mai	den Surname)	
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121 d'be (fental arke	o Be	19a. Informant's Name/Relationship (Type Print)	19b. Mailing Ad	dress (Street and Number	er or Rural Route Number	r, City or Town, St	ate, Zip Code)
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "naturn!", or items 23n or 28a-f she imatic event, the Medical Examiner must be notified at once	۲	Decilord Ungar	CON TO BUT	her 107/7	Parc Prof/C.	7. HAURE TO	CIRACE, 1	Nd. 21078
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×6 th cer ttendi	icia	1 Yes 2 No 9 Unknow	4 Pregnant at time of	of death 5 Othe	(Specify)			
Box e death of the atter	Phys	hardened hardened	9 Onknown	not reculting in the Unit	edving cause given in Par	t I. 23e. Did tob	acco use contribut	te to the cause of death?
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Div the Hospital or hin 24 hours after the Funeral Dif	Z Z		sician: To the best of my kno	wledge, death occurre	d at the time, date and pla	ce, and due to the caus curred at the time, date	e(s) and manner as and place, and due	to the cause(s)
Division To the Hospital or Attendin within 24 hours after death To the Funcard Director: A	Medical	one) 2 Medical Examin	ner:On the basis of examinat and manner stated.	ion and/or investigation			29d. Date signed	(Month, Day, Year)
	์ รั	29b. Signature and title of certifier	()1 00		29c. License number		August 5, 20	
1		Welling Ir	he Ishell		O.C.M.E.		, tagast 0, 20	
Mand	1	30. Name and address of person wi	no completed cause of death	(Item 23a)	nn Ctroot Boltimers	MD 21201		
2 17			Assistant Medical Exa		nn Street, Baltimore	, IVID 2 120 1		
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Funeral Director		Social Security Number	6. Sex 1XXM 2 F	7. Age (In yrs. la		Under 1 Ye		Min.	Date of Birth	Fore	Birthplace (State or eig NEW YORK Country)
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ion of Virtending Physicath.	OL: 27	. Manner of Death Natural 5 Per	28a. Date		28b. Time of Injury 1425 hrs	/ 28c. tr	njury at Work	c? 28d Sut		ow injury occurred shot	4
<u> </u>	Certification:	Suicide 6 Co	uld not be	e of Injury - At h	ome, farm, street, fa	actory, offic	e building, e			treet and Number of ate) e Drive, Joppa, M	r Rural Route Number, City
Di To the Hospital within 24 hours a To the Funeral	_ 29	a. Certifier 1 Certifying	Physician: To the be aminer: On the basis	of examination a	ge, death occurred and/or investigation,	at the time, in my opin	date and plation, death oc	ace, and due	to the cause time, date a	e(s) and manner as and place, and due t	stated. to the cause(s)
To with To com	29	b. Signature and title of certif	and manner s	With the state of		29c. Lice	ense number			29d. Date signed August 12, 20	(Month, Day, Year)
	30	Name and address of person	(se of death (Item	n 23a) Penn Street			201			
2		Ling Li, MD Assist		edistrar's Signat		Janumon	J, 1VID E 12				

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Margaret Ellen Huesman 08/18/2007 12:30 aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Charlestown Care Center Renaissance Baltimore 5. Social Security Number Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, **Funeral** Birthplace (State or Foreign Country) Months Days Hours Min 75 Director 219-30-9182 02/03/1932 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits show 28a-f sh notified Director MD 1 ☐ Yes 2 1 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 709 Maiden Choice Lane 21228 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ White Specify: 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant <u> Health Care</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F L. Omer Huesman Ellen R. Houck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 ls Gerard E. Huesman (Brother) 6305 Angel Rose Court, Columbia, Maryland 21044 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₹ Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/22/2007 | Baltimore, Maryland New Cathedral 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Breast co Due to (or as a consequence of): cancer disease or condition resulting in death) ans /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed use as the burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Month Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 ☐ Unknown been signed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ COPD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an has page 2 certificate 1□ Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: · this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation death. 2 Accident al or Attendi s after death. 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 29c. License number Maiden Chaice Lane Outbroville MD address of person who ompleted cause of death (Item 23a) (Type, Print)

5

State Registrar

MD

32. Registrar's Signature

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31. Date iled (Month, Day, Year)

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		1 State Registrar		rtificate of Dea		Re	g. No.	2691; J		
Physic /Medi		Decedent's Name (First, Middle, Last) David	A. Hort	on	×	2. Date of Death Month	Day Year 19, 2007	3. Time of Death		
Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Locat	ion of Death	-	4c. County of Death			
		Sinai Hospital 5. Social Security Number 6. Sex 7. Age (In vi	rs. last birthday)	If Under 1 Year If Ur	Balti nder 24 Hrs.	more 8. Date of Birth		N/A nplace (State or Foreign		
Funeral Director		214-44-8710 Usual Residence of Decedent	60 Yrs.	Months Days Hou		(Month, Day,	Year) Co.	Maryland		
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or 28	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	untry?		
sath v s 23a nust	eral	3511 Virginia Avenue	11.0	1	21215	-16 - V N -		S.A.		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylanc Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 M Married 1 □ Never Married 2 M Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of Hispanic If Yes, specify Cuban, Me 1 ☐ Yes 275 No Spec		city Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:			
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be file	Be	17. Father's Name (First, Middle, Last)		18. M	lother's Name	(First, Middle, M.				
hould d Mer marke matic	P	William Horton 19a. Informant's Name/Relationship (Type. Print)	10h Mailir	on Addrona (Street and No	umbar ar Dura		ncy Horton			
nd 2 s lith an 27 is i		Geneva Horton Wife		ng Address (Street and Nu 3511 Virginia Aver				ip Code)		
s 1 ar of Hea item;		20a. Method of Disposition 20b	. Place of Dispo	osition (Name of matory or other place)			Oc. Location - City or T	Fown, State		
Page nent c int: if iry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		wn Cemetery & C	hapel	08/24/07	Baltimo	ore, Md.		
permit. Departr Imports any inju		21. Signature of Funeral Service Licensee		2. Name and Address of Fa	acility	eral Service.	P. A.			
100		23a. Part1. Enter the / isease, or complications that caused the de	ath. Do not ent	1300 Euta	w Place B	eral Service, altimore, Mo respiratory arres	i 21217 st.	Approximate		
Physician		shock, or heart silure. List only one cause on each line. Immediate Cause (Fl. al	1 int	fa-chi'n				Interval Between Opset and Death		
/Medical		disease or condition resulting in death) Due t (or as a conse		PCP CITY 1				124)		
Examiner		Sequentially list conditions, b.								
ed ist	ine	Sequentially list conditions, and the sequentially list conditions, ause. Enter Underlying Cause (Disease or injury that initiated events c.	equence of):							
tificate be executed g physician and as the burial-transit	Examiner	that initiated events c. Due to (or as a conse	equence of):							
e be e rsiciar e buria	cal	Ca								
eath certificate be executed attending physician and for use as the burial-transit	ledical									
th cer tendin r use	Physician/IV	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf preg 1□Live birth 2□Fe		Ectopic pregnancy			23d. Date of deliv	*		
e dea the att	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown		Other (specify)			Month	Day Year		
hat th d by 1 detach	Phy	Part II. Other significant conditions contributing to death but not re	asulting in the ur	nderlying cause given in P	art I	23e Did toba	acco use contribute to	the sauce of death?		
signe d be	d by	Non in all cell lun, can	(<u>(</u>	ndenying dadde given in t	arri.	1 Nes		bably 4 Unknown		
w req	lete		le*		-	24a. Was an				
ne la e has age 2	Completed					autopsy perform	prior to co	topsy findings available ompletion of cause of		
rtificat tor, p	Be Co	25. Was case referred to medical	1	26. P	lace of Death	1 Yes 2 Check onl one	No 1 □Yes	2 No		
nysici nis ce i direc	70 B	examiner? 1 ☐ Yes 2500 Hospital: 1 ☐ Inpatient	ER/Outpatien	Other			ce 6 □Other (Spec	ify)		
To the nospital of Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Luneral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	tion:	27. Manner of Death Salatural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injury at Work? M 1 ☐ Yes 2		8d. Describe how	injury occurred			
or Arter fter dea Director in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At building, etc. (Spec	home, farm, stre cify)	eet, factory, office	2	8f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,		
ours a herai [29a. Certifier 1 ertifying Physician: To the best of my ki	nowledge, death	n occurred at the time, date	e and place a	nd due to the cau	(ca(c) and mannor ac	stated		
o the hos vithin 24 h To the Fur	Medical	one) Medical Examiner: On the basis of examiner and manner stated.	nation and/or in	vestigation, in my opinion,	death occurre	ed at the time, dat	e and place, and due	to the cause(s)		
Nit of contract of the contrac	2	29b. Signature and title of conflier		29c. License numb		,	d. Date signed (Month	Day, Year)		
		20. Name and address the second who considered access of the time.	om 22=\ /7:	D Ø Ø	01/0	0)	00/21/	てロリナ		
12		30. Name and address in person who completed cause of death (Its	22 S	Print) Greene St	Ba	Homero	a am	21201		
Sta	te	31. Date flies (Month, Day Year) 32. Registrates Sig	The D	The Correction	,					
Registr	ar	MUU A A LOUI	15							

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ionel Johnson	1	- For State	ate of Maryland		ificate of De		эптаг глуу				7 2694	
Physicia		Registrar 1. Decedent's Name (First, Middle	e,Last)		meate of De		2.	Date of Death	. No.		3. Time of Death	
Medical Examin	1.7	Lionell		ctis		Johnson	1 /	Month August 14,	Day Ye 2007	ar	1325 hrs	
7000		4a. Facility Name (if not institution	, give street and number)			ty, Town, or Location	on of Death		4c. County	of Death		
		Harbor Hospital Cente				ltimpre	·	(B) (I	The state of the s			
Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. la:	* *		Inder 24Hrs. 8	8. Date of Birth	Birth(MM/DD/YYYYY) 9. Birthplace (State or Foreign Country) M.D.			
Director		219-98-5072	X M 2 F	25	Yrs.			09 04	4 81	Cou	ntry) MD	
any.	_	Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Location						10d. Inside City Limits	
		MD NA		,,	Baltin	ore			1 XYes 2 No			
Aaryland 28a-f show	홝	10e. Street and Number				Zip Code		10	log, Citizen of What Country?			
th the Maryland 23a or 28a-f sho notified at once,	Director	3427 Spellma	n Road			2122	2.5		U.S.A.			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status	12. Was Decedent		6. 13. Was De	cedent of Hispanic	Origin? (Spec			an Indian, Black,		
leath y	Funeral	1X Never Married 2 Ma	Armed Forces?	If Yes, s	pecify Cuban, Mexic	can, Puerto Ri	can, etc.)	Whi	ite, etc.	4,000		
after c		3 Widowed 4 Dive	orced If Yes, Give Year		2X No spec			Specify.		lack		
natur	eted by	15. Decedent's Education (Spec			16a. Decedent's Us during most of	sual Occupation (Gi	live kind of wor OT use retired	k done i)	16b. Kind of E	Jusiness/In	ndustry	
16 n 72 h nan "r	Set 1	Elementary/Secondary (0-12)	College (1-4 or	5+)						0 - 1	1	
withi grene her th		10th grade 17. Father's Name (First, Middle,	na Last)		S	tudent 18.Mot	ther's Name (F	irst, Middle, M	Tesst		Lege	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene Itanic If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Bec						Jewel	Johns	on			
212 212 Ment Ment mark		Curtis Dredo	nip (Type, Print)		19b. Mailing Add	ress (Street and I	Number or Rur	al Route Num	ber, City or To	wn, State,	Zip Code)	
MD id 2 sho ilth and in 27 is aumati		Jewel Johnso	n-Mother		3427 Sr	ellman	Road,	Balt	imore	, Md	21225	
Titeral File		20a. Method of Disposition 1 Burial 2 Cremation	2 Domoval from St		Place of Disposition rematory or other p		/.	Date	20c. Location	ı - City or	Town, State	
MO Pages ent of int: I		4 Donation 5 Other Sp		ale	Mt. Zio	on	8/22	/07	Balt:	imor	e, MD	
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra	1	21. Signature of Funeral Service				and Address of Fa						
		23a. Part I. Enter the disease, or	Total	gn	14300) Wabash	a Ave,	Balt	imore,	Md	21215 Approximate Interval	
Physician // // // // // // // // // // // // //		23a. Part I. Enter the disease, or failure. List only one cause	on each line.				as cardiac or i	espiratory arre	St, SHOOK, OF	Carr	Between Onset and Death	
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Narcotic (methadone) intoxication Due to (or as a consequence of):											
100		Sequentially list conditions,	b.	oquenoe en	<i>j.</i>							
	Je.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of):							
	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	equence of);							
outed and ransit	Ě	Cronto resouring in decary 2001.	d									
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical E	X UNPENDED	X AMENDED a.27	.28a-f	, perME,g87	0, 8/31/07	TT					
760, icate be physic the bur	Me	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outco	me of pregr	nancy	- 🗀 -			23d. Date Month	,	Day Year	
68 certification	lä.	past 12 months?	1 Live birth Pregnant a	t time of de	2 Fetal d	eath 3Ec (Specify)	ctopic pregnanc	Зу	i		Jay Teal	
Box death	Physician/	1 Yes 2 No 9 Uni	nown 9 Unknown		o outer							
ਂ ਦ ਣ ਤੋਂ		Part II. Other significant condit	ions contributing to deal	h but not re	esulting in the unde	rlying cause given i	in Part I.				the cause of death?	
5, P	d by										pably 4 Unknown	
ords								24a. Was autop	sy	prior to c	topsy findings available completion of cause of	
Cecc	Completed							1 Yes		death? 1 ✓ Ye	es 2 No	
entific ctor, p	a l	25. Was case referred to medica				26.Place of De		nly one)				
of Vital Records, P.C ing Physician: The law requires that After this certificate has been signed tuneral director, page 2 should be dete	O B	examiner? 1 ✓ Yes 2 No			ER/Outpatient 3	DOA Other			Residence 6		.	
Ing P	ä	27. Manner of Death 1 Natural 5 Percentage	28a. Date of Inj (Month, Day,		28b. Time of Injury	1 Voc 5	2 V No	28d. Describe I	now injury occ	irred		
Sior	atic	= Pen	stigation Fnd O/ 12		FNd 12:25 ome, farm, street, fa	pm		ink	Street and Nur	mber or Ri	ral Route Number, City	
Division Estate of the carbon at Directors al Directors	Certification:	3 Suicide 6 X Coul	d not be rmined (Specify)			ictory, office ballons	-	or Town, S	tate)		more, MD	
Division of Vital Records To the Bospital or Attending Physician: The law requi within 24 hours after centh. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should												
the II hin 24 the F	Medical	(Check only one) 2 Medical Exa	miner:On the basis of exa	mination a	nd/or investigation,	in my opinion, deat	th occurred at	the time, date	and place, an	d due to th	e cause(s)	
To with	Mec	29b. Signature and tiple of certific	and manner stated	1		29c. License num	mber		29d. Date si	gned (Mo	nth, Day, Year)	
b. 1		XIII	XV\/			O.C.M.E.			August 1	5, 2007		
OFFE		30. Name and address of persor							L			
801		Susan Hogan MD.				treet, Baltimor	re, MD 212	01			10	
	ate	31. Date filed (Month GDay Year)	2007 Registr	ar's Signal	ire Annual							
Regist	uali	. 10 - 10 10										

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		-	For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H <i>rtificate of L</i>			giene Reg. No.		259112		
			Decedent's Name (First, Middle, Last	st)				2. Date of Dea	ath		3. Time of Death		
44	Physici	an	ROSA LEE	JOHNSON				Month	Day 1.6	Year 2007	11:30 a M		
	/Medic	_	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	August		inty of Death	111:30 a		
*	Examin Funeral		FRANKLIN SQUARE H 5. Social Security Number 6. S	OSPITAL CE	(In yrs. iast birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	h v, Year)	ALTIMO 9. Birthp Cour	ORE CO place (State or Foreign ntry)		
, \$6	Director		220-12-5741	I'M ZLAT	89 Yrs.			Oct. 1	1 1917	MZ	ARYLAND		
	and *	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	10d. Inside City Limits		
	/anyl	ō	MARYLAND BALTI	MODE	D7\T1	TIMORE					1 ☐ Yes 2XXNo		
	the t	Director	MARYLAND BALTI 10e, Street and Number	MOKE	DAL.	10f. Zip Code			10g. Citizen	of What Cour	ntry?		
	with I bu		12144 EASTERN A	VENUE		2122	2.0		U.S	S.A.			
	The 23	era	11. Marital Status	12. Was Decedent 8	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-		Race - Americ			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be muitted at ance.	by Funeral	XXNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🔼 N If Yes, Give Year or Dates:	10	1 ☐ Yes 2 ☑ No	Specify:	o rican, etc.)		Black, White, ^{ec<i>ify:</i> BLAC}			
Ö	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occupa	ation during most of work	kina	16b. Kind o	f Business/In	dustry		
2	thin 7	npie	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	kind of work done of DO NOT use retired)	9					
2	er th	Con	12th grade		GUA	RD			S.S.				
Maryland	al Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam						
<u>y</u>	Ment Ment arke	2	CARROLL W JOHNSO)N		-		LYONS J					
ar	2 sho and iem		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street a							
2	and ealth m 27		Elsie M. Williams	/Niece		meron Ct.		Baltimor Date		on - City or To			
ore	ges 1 t of H If ite or otl		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	osition (Name of matory or other plac	1			•			
Ē	Fattment:		4 □ Donation 5 □ Other (Specify	A-1 -		REET U.M.		22-07		E, MARY			
Baltimore,	Departiment of the post of the		21. Signature of Funeral Service Lice	1966	Ŵ	ILLIAM C 3 321 S PHI	BROWN CON LADELPHIA	MM FUNER A BLVD,	AL HOM ABERDE	ME-HARI EEN, MI	FORD, P.A. D 21001		
	S to the state of		23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List phy one cause on each line. Approximate Interval Between Onset and Death										
	Physician		Immediate Cause (Final disease or condition	PA	UMDI	na					1 das		
1	/Medical		a. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
y.	Examiner		Sequentially list conditions,	b. 1462	nei	nek					Jucare		
0	P 15	inei	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):						•		
3	icate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):								
8760,	be ex icien buria	ai E		240 (5) (5)									
387	phys the	dicai	•	d									
.O. Box 6	ne death certifi the attending hed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 VN No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d.	Date of deliv	rery Day Year		
S, D	law requires that the de as been signed by the a 2 should be detached f	b	Part II. Other significant conditions of	contributing to death b	ut not resulting in the	underlying cause give	en in Part I.	23e. Did to	SI		the cause of death?		
Record	o - o	Completed							osy ormed?	prior to co death?	opsy findings available ompletion of cause of		
a	iiclan: Th certificate rector, pag	e Co	25. Was case referred to medicat				26 Place of Des	1 ☐ Yes	2 2 No	1 🗌 Yes	2L No		
Vital	Physician: this certifier ral director, I	100	examiner?	Hospital:	ent 2 ER/Outpatie	ent 3 DOA Oth	or	lome 5 ☐ Resid		Other (Speci	ıfv)		
of	<u>a</u> = <u>a</u>	To To	27. Manner of Death	28a. Date of Inju	ry 28b. Time			28d. Describe			-77		
O	Attending r death.	igi	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	y Year) Injury		Yes 2 □No						
Division	i gi fe o	Certification:	3 Suicide 6 Could not be determined	288. Place of inj	ury - At home, tarm, s c. (Specify)	treet, factory, office		28f. Location (: City or To		umber or Rui	ral Route Number,		
	To the Hospital or Attenwihin 24 hours after deat Verbra Eduaral Director: completely filled in by the	edical C	29a. Certifier Check only one) Certifying Pl	nysician: To the best miner: On the basis o and manner st	f examination and/or i	ath occurred at the tin	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)		
	Vithin O the	₹ E	29b. Signature and title of certifier)		29c. Licens	e number		29d. Date si	igned (Month	. Day, Year)		
)	~ > - 0) (/		>	34931		81	120/0	19		
	(30. Name and address of person who	completed cause of c	leath (Item 23a) (Type	, Print)	,,,,,		-/	1			
	P		Ann C. Morrill M	.D. 4136 E	В Е. Јорра	Rd., Balt	imore, M	Maryland	21236	,			
di Sala	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 2	32. Registr	ar's Signature	parte							
			LION W W	.9									

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			for State Registrar	State of Ma	aryiand / Depa <i>Cei</i>	rtificate of l			ene No. 2. U. U.	7 25949
	Physici	an	1. Decedent's Name (First, Middle	, Last)	IEA	JKINS		2. Date of Death Month	Day Yea	3. Time of Death
	/Medi	al	CLARENCE 4a. Facility Name (If not institution	give street and number)			Location of Death	AV6UST	4c. County of De	
<i>p</i> .	Examir	ier	-a. I dolley Harte (If not monution	,	10.00	4b. Oity, Town, or			4c. County of Di	
	Funeral Director		5. Social Security Number	6.536 Beards Hill	Yrs.	If Under 1 Year Months Days	If Under 24 His. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. E	Harford Birthplace (State or Foreign Country)
125	pu ,		Usual Residence of Decedent		72			Nov 18	, 1934	No. Carolina
	laryla shov	J.	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	the N 28a-f notifie	Director	Maryland 10e. Street and Number	Harford		10f. Zip Code	Aberdeen	100	. Citizen of What	1 Yes 2 □ No
	3a or					Tot. Zip Code		100	g. Chazen or vvnat	Country?
	death	Funeral	536 Beards Hill Roa 11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi	21001 ispanic Origin? (Spe In, Mexican, Puerto I	cify Yes or No-	14. Race - Ar	J.S.A nerican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at once.	by	1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced		10	nr Yes, specify Cuba 1 □ Yes 2 🛣 No X	Specify:	Hican, etc.)	Black, W Specify:	
2-0	72 ho natur dical	eted	15. Decedent (Specify only highes	s Education	16a. Deced	dent's Usual Occupa	ation	16	b. Kind of Busines	Black ss/Industry
2	/ithin ne. han " e Mec	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) life. L	DO NOT use retired	during most of workin)	' ⁹	_	
	filed within Hygiene. rther than "		17. Father's Name (First, Middle,	net)		Farr	n Laborer	(First Stiddle St		m Industry
Maryland	d be f	Be c					18. Mother's Name	(FIIST, MIGGIE, MA	iden Surname)	
<u> </u>	should ind Men marke umatic	은	And 19a. Informant's Name/Relationsh	drew Jenkins ip (Type, Print)	19b. Mailin	ng Address (Street a	and Number or Rura		ha Jenkins Sity or Town State	Zin Code)
	and 2 sealth ar									., Zip Oddej
Baltimore,	item item		Rutha Eakin Sister 20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other place	ill Road Aberd		c. Location - City	or Town, State
Ē	Pages nent of I ant: If ite ary or o		1 Burial 2 □ Cremation 4 □ Conation 5 □ Other (Sp	3 ∐Removal from State ecify)				00/04/07	D-#	
alti	permit. Page Department (important: If any Injury or once.		21. Signature Funeral Service L	111	1 1	estern Cemel		08/21/07		more, Md
_	20 E E 9) loy	111.65	Con 1	Estep E	3rothers Fune	ral Service, F	P. A.	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each lin	the death. Do not entile.	er the mode of the	hiam as acusti	and was	21217	Approximate Interval Between Onset and Death
7	Physician /Medical	İ	Immediate Cause (Final disease or condition resulting in death)	_a. Gast	lic ca	ncer				Months
	Examiner			Du to (or as	a consequence of):					
		er	Sequentially list conditions,	b. Due to (or as	a consequence of):					
p .	od d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	an an irial-tr	Exa	resulting in death) Last	Due to (or as	consequence of):					
68760,	tificate be executed g physician and as the burial-transit	edical	,	d						
			IF FEMALE:				-			
Box	e death o	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
0.	nat the d by t etach	Phy	9 Unknown		A mak man liking in the com	alant dans a second	- i- B 44	00 5:41		
Records, P.	The law requires that the death cer tte has been signed by the attendin age 2 should be detached for use	þ	Part II. Other significant conditio	ns contributing to death bu	it not resulting in the ur	denying cause give	en in Part I.			to the cause of death? Probably 4 Junknown
ပို	law l	Completed						24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
		Sol						performe	d? death d?No 1∐Ye	?
Vital	ysician; iis certific director,	Be	25. Was case referred to medical examiner?	Hospital:		Otho	26. Place of Death			
ō	Phys r this ral dir	<u>유</u>	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie			4 Li Nursing Hon		e 6 □Other (Sp	pecify)
Division or	tending Pheath.	tion	1 Matural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	28c. Injury Work M 1 □ Y	?" /es 2□No	8d. Describe how	injury occurred	
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ā	s afte	Sert	4Hornicide	building, etc	. (Specity)			City or Town, S	State)	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical (29a. Certifier (Check only one)	Physician: To the best of examiner: On the basis of and manner sta	examination and/or inv	occurred at the time restigation, in my op	ne, date and place, a pinion, death occurre	nd due to the caused at the time, date	se(s) and manner e and place, and d	as stated. ue to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier			29c. License		29d.	. Date signed (Mo	nth, Day, Year)
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	0		30. Name and address of person w	tho completed cause of de		N. Chan	78303 Les St	TONSON	NMD	21204
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 08-20-2007 Physician 10:10 AM Daniel Norman Jakubiak /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Street Hart Heritage If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days **Funeral** Months Hours 1**X** M 2□F 67 218-36-8409 01-01-1940 <u>Maryland</u> Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a State 27 is marked other than "natural", or Items 23s or 28s-f show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Wye Mills Maryland Talbot Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21679 13457 Blackberry Lane Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? TY□Yes 2 □No 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Port of Baltimore Longshoreman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental ty Important: If Item 27 is marked oth eny july or other traumatic even potes. Helen Gos Chester Jakubiak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13457 Blackberry Lane Wye Mills, MD 21679 Christopher Jakubiak (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08-23-2007 Pylesville, Maryland St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySchimunek Funeral Home of BelAir 21. Signature of Funeral Service License Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Reaction INFLAMATORY Syskn.c 6 W/C1 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ VASUIAN MISERSI 1 Yes 2 No 3 Probably 4 Onknown EVENIAL Be Completed Disorder 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No certificate 1□ Yes 2□ No After this certification, property of or Attending Physician: 26. Place of Death (Check only one) Assisted 25. Was case referred to medical examiner CARR Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical pletely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2007 August 21, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bul DIN MO MACPHALL 21014 SPERTY N D. G. E.D. _ 6015 32. registrar's Signature 31. Date filed (Month, Day Year) AUG 2 2 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** David Jackson Jeffreys 20 2007 Aug. 9:50 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson 6. Sex If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 ☐ F Director 85 May 31, 1922 North Carolina 242-30-0535 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 1547 Elrino Street 21224 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 7 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White þ 3 Nidowed 4 Divorced WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Manufacturing 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Billie Jeffreys ပ္ Alma Coppedge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Jeffreys (Son) Bluebird Lane Murrells Inlet, S.C. 29576 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Other (Specify) Stanislaus Cemetery 8/24/2007 Baltimore, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the burial-tran Due to (or as a consequence of): use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Churles St. Balto, md 2, 20%

Registrar DHMH 17 Rev 1/2001

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 21, 200 Keiser /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BAltimore HIGHWAY BENING If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Aga (in yrs. last birthday) 6. Sex Social Security Number Months **Funeral** 1**X** M 2□ F 217-09-0597 86 ec 20 1920 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show 1 XYes 2 No item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at BAltimore Director MATYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number BroENING 21224 1104 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Deceden Ever in U.S. Armed Forces? Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: White filed within 72 hours after 1 ☐ Never Married 2 Married 2 No 1 ☐ Yes 2 XNo Specify: altimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Milton Electric Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Electrician 18. Mother's Name (First, Middle, Maiden Surnar 17. Father's Name (First, Middle, Last) Be (Keiser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4 BAHUMD 21224 Broening Keiser Spouse Oc. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Daffe 20a Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State BAHIMORE, Aug 23, 07 reenmount 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Puneral Service Licensee N. CONKLING Joseph 263 1150 BALLO MD ZIZZA Street 5. Approximate Interval Between Onset and Death 23a. Part1. Enter the dispase of complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. It is to not enter the mode of dying, such as cardiac of respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician equence of) /Medical Due to (or as a cons MONTHS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death as been signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 1 ☐ Yes 2 ☐ No 1□ Yes or Attending Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 ■ Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death.

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6

State Registrar of person who completed cause of death (Item 23a) (Type, Print) chwAltz 3512 Newland M. D.

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

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) 89F	9	21. Signature of Funeral Service Licensee 22. Name and Addless of Facility Duda-Ruck Funeral Home of Dundalk, I 7922 Wise Avenue Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											21222		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar / Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 08 16 2007 11:15 P M Kenneth Theodore Letke /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Parkville, Maryland Oak Crest Care Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1XM 2□F Maryland 05/04/1927 Director 80 216-28-2746 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland r 28a-f show notified at 10a. State 10h County 1 ☐Yes 2X No Funeral Director Havre de Grace Harford MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or 2 must be n 1715 St. 33 Lathe, Kenneth U.S.A. James Terrace 21078 death v Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 0 1 ☐ Yes 2 💆 No Baltimore, Maryland 21215-0036 Specify If Yes, Give Year or Dates: WW II Specify: þ White 3 XWidowed 4 ☐ Divorced 'natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry nd Mental Hygiene. marked other than "natu matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BGE Service Technician 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental Marie Jones William Theodore Letke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau once. 1715 St. James Terrace - Havre de Grace, MD 21078 Mary L. Mergler (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. Michael Luth. Cem. 08/20/2007 Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 60 11750 Belair Road - Kingsville, Maryland 21087 assakn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 12 CVdisease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Vear in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 21 No 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Tes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Condition of the date of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number 1241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4400 120 1H moram 31. Date filed (Month, Pay Year) AUG 2 32. Redistrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrer	State of Maryland		rtment of He tificate of D			giene Reg. No.	007	2594)
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	Funeral		Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 3 - 27 -	th y, Year)	Cou	
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	and w	1	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			ring Physician: To the best									
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12		30. Name and address of person	on who completed cause of the complete of the	death (Item	n 23a) (Typ	e, Print)	565	S4 - 20	3 R	ltr	nove u	(D 21204
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 21, 2007 **Physician** Robert A. Mellendick 8:11 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3 Rumford Drive #303 Catonsville Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year March 4, 1 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☑ M 2 □ F 79 219-22-7665 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director Baltimore Maryland Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. P 3 Rumford Drive #303 21228 USA Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∑Yes 2 No If Yes, Give Year or Dates: 1952–60 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White þ 3 Widowed 4 Divorced 'natural", Completed r than "natur the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Savings & Loan Savings & Loan Officer marked other Department of Health and Mental High Important: If Item 27 is marked other any Injury or other traumatic event, I once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Veronica McCurnin William Mellendick ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catonsville, MD 21228 Doris Mellendick Wife 3 Rumford Drive #303 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 8-27-2007 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Juneral Service Licensee 1630 Edmondson Avenue; Catonsville 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) CHOLANGIOCARCINOMA **Physician** 6 months Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2DNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation in 24 hours area the Euneral Director; After and the funding in by the funding the funding the funding the funding the funding 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Insertifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D16354 AUGUST 22, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AVE BALTIMORE MD 21229 900 E.W. COLE 32 Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 19, 2007 4:55 A.M Michael R. Miller August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ellicott City Nursing & Rehab Ellicott City Howard If Under 1 Year If Under 24 Hrs Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 1 F 16,1925 217-20-0484 Maryland Director 81 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 'natural', or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 6113 Collinsway Road 21228 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1944–46 1 □ Never Married 2 x Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Cost Estimator Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Miller Rose (Semerad) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dolores H. Miller Wife 6113 Collinsway Road; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Holy Redeemer Cemetery 8/22/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Li once. 1630 Edmondson Avenue; Catonsville MD 21228 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (archavaxular Athero sclew lic **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Examin rabete physician and the burial-transit Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has li irector, page 2 s autopsy performed? Yes 22 No 2 No 1□ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30641 anne 201-109 Back Rover Neck Road Rathmon Mayland 21221 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramest, Sechapathi 32. Eggistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of M	arylan		artment of I			F	Reg. No.		2.5950
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Examine Funeral Director		4a. Facility Name (If not institution, BALL MUREV) 5. Social Security Number 216-26-7318	A Medica	L C	Partel Past birthday) Yrs.	4b. City, Town, of A Control of International Internationa	+: mo	Re	B. Date of Birt	h	County of Dec	
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21215-0036 d within 72 hours af giene. er than "netural", or I'm Medical Erent	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	's Education it grade completed) College (1-4or	5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire LONG:	during most	of working	7	16b. Ki	nd of Busines Bethleh	s/Industry em Steel
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M62 John 2 27 is		19a. Informant's Name/Relationsl Joan S. Mohorn Wife	nip (Type, Print)		19b. Mailir 34	ng Address (Stree 02 Callaway	t and Numbe Avenue	Por Rural Baltimo	Route Numbere, Maryla	ind 2	1215, State,	Zip Code)
Page ment o ant: If ury or		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp		C	rnson Fo	sition (Name of natory or other pla rest Veterans	s Cemete	-i y	3/21/07		Owings	or Town, State Mills, Md.
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To the Hospital within 24 hours & To the Funeral completely filled	Medical	29b. Signature and title of certifie	and manner s			29c. Licer	nse number			29d. Dat	te signed (Mo	nth, Day, Year)
O\ Sta Registr		30. Name and address of person THOMAS, C 31. Date filed (Month, Day, Year) AUG 2 2 2007	who completed cause of MEN M	1	n 23a) (Type.	Print) NORTH G	30/16 Reen!	25#	Reet B	BALT	15/20 mule	07 MD21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Mae Alma Mason Augus 2007 6 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner ivista Medical Center P lato harles 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Ye. April 11, 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Country) New Jersey **Funeral** Days Year) 1 □ M 2 🗑 F 86 156 07 4282 Director 1921Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 □ Yes 2\ XNo White Plains Directo Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20695 United States 6965 Bensville Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: 3 X Widowed 4 Divorced White Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natuu any injury or other traumattic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home Mason, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Fauver Raymond Stormes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14230 Enchanted Place, Charlotte Hall, MD 20622 19a. Informant's Name/Relationship (Type. Print) Wayne Mason (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Aug 21 ate 2007 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery Suitland, Maryland 21. Signature of Funer II Service Ly enses 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 1000251 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONZ **Physician** disease or condition resulting in death) /Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examine ed by the attending physician and detached for use as the burial-transit certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 👿 No 9□Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death/but not resulting in the underlying cause given in Part 23e. Did toba o use contribute to the cause of death? Division or Vital Records, þ has been signed to the point of 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy this certificate 1□ Yes Physician: 25. Was case Be 26. Place of Death (Check only one) examine Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yg 2 patient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Matural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: or Attending 5 Pending investigation (Month, Day Year) death. 1 ☐ Yes 2 ☐ No To the Funeral Director: 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide termined hours after To the Hospital

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29a. Certifier

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AUG 2

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Chan M.D

2 2007

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

enna Medical Center 7C Post Office Road

29c. License number

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State Registrar DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

AUG 2 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

31 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 450 MY SSANTHI 2007 /Medical 4a. Facility Name (If not institution, give street and number Examiner Town, or Location of Death 4c. County of Death Homere VURSING last birthday If Linds 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months 1 □ M 2 🗆 F Days Hours Min. 212-30-5663 Director Usual Residence of Decedent the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ✓ Yes 2 ☐ No Completed by Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23: 21214 USA . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No 3 Widowed 4 □ Divorced Specify: Whik the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ traumatic Lemonatis Kessie Lemonakis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trait Skwart 1060 Baltmore mo 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 8-21-07 21. Signature of Funeral Service Licensee Bradley - ASKTON Funeral Home Spring Rd PA, 2134 WILLOW 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as carr lac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed as the burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mont 1 ☐ Yes 2 ☐ Mo Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use corribute to the cause of death? 9 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed res 2 certificate death? 1 ☐ Yes Division or Vital 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ျှ 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 27. Manuar of Death 1 Natural completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Rag. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Year **Physician** 12:40 p MILLER S **JOSEPH** 2007 18 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CITY HOSPITAL SIMAI OF BALTIMORE 9. Birthplace (State or Foreign Country)

MD If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 12/20/1920 1 M 2 □ F Days MD 86 216-14-8703 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count BALTIMORE 1 Yes 2 No BALTIMORE MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21209 U.S.A. 6808 TIMBERLANE ROAD by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 □ No NAVY If Yes, Give Year or Dates: WW T 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No WHITE Specify Specify: 3 ♥ Widowed 4 □ Divorced WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BALTIMORE COTTON FELT College (1-4or 5+) Elementary/Secondary (0-12) OWNER other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any injury or other traumatic event, DRB. 17. Father's Name (First, Middle, Last) Be KIRSH MILLER ANNE LEWIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4 ASTON COURT - OWINGS MILLS, MD 21117 ROBERT MILLER / SON 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ARL'INGTON" CHIZUK (1909) AMUNO CONG. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/21/2007 BALTIMORE, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 days Physician ASPIRATION Pricumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physiclan/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient ٩ 3□ DOA 28a. Oate of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 🗀 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier lue MD(MBBS) RES- OOC 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE SINAI SRIRATNA KONERU 32. Registrar's Signature 31. Date liled (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	afyllah		mment of F rtificate of		ınd Menta		ene . No.	7 269	E 3
	Physici /Medic		Decedent's Name (First, Middle,	Last) Eileer	n	Ε.	Meye	ers	Mo	te of Death onth	Day Ye	3. Time of D	M
	Examin		4a. Facility Name (If not institution,	give street and number))		4b. City, Town, o	r Location of		igust	4c. County of E		
			8187 Gray Haven 5. Social Security Number		7 / In I		Dunda		Miles I a		Balt		
S.	Funeral Director		219-20-5542 Usual Residence of Decedent	1 M 2 M F 80		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Mo	te of Birth onth, Day, Yo ch 8	ear)	Birthplace (State or Country) Maryland	Foreign
	/land ow at		10a. State 10b. County		10c. City	, Town or Lo	cation	-				10d. Inside City	Limits
	a-f sh	ctor	Maryland B	altimore				Dun	dalk			1 □Yes 2	2 <u>/C</u>] y No
	vith the	Director	10e. Street and Number 1946 Holborn	Poad			10f. Zip Code			10g	. Citizen of What	t Country?	
	leath v	Funeral	11. Marital Status	12. Was Decedent	Ever in II 9	S 13 V	21222		in? (Capair V		nited St	tates American Indian,	
38	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces?)	If	Vas Decedent of H f Yes, specify Cuba I □ Yes 2€XNo	an, Mexican, Specify:	, Puerto Rican,	etc.)		Vhite, etc.	
21215-0036	72 hou natura dical E	Completed	15. Decedent's (Specify only highest	Education grade completed)	-	16a. Deced	lent's Usual Occup	ation	of working	16	b. Kind of Busine	White ess/Industry	:
121	within ene. than "	mple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. C	kind of work done of NOT use retired		or working				
	filed \ Hygie	ပ္ပ	12 Years 17. Father's Name (First, Middle, La	ast)			Homemak		's Name (First,	Middle, Mai	Own Ho	ome	
<u>dan</u>	uld be Mental irked o	To Be	Michael Memme	1					a Dwyer		acon Garriamo,		
dar	2 should n and Men Is marke raumatic		19a. Informant's Name/Relationship	, ,		!	g Address (Street						
ė,	1 and Health em 27 Ither tr		Mrs. Karen E. Ti 20a. Method of Disposition	tus (Daughte					oad Du			and 21222	
E O	Pages nent of I ant: If ite		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				sition (Name of natory or other place Cemetery		8/20/20		c. Location - City	ror lown, State Se, Maryla	~d
Baltimore, Maryland	permit. I Departm Importar any Injui		21. Signature of Funeral Service Lie		2	22. Du	Name and Addres	ss of Facility Funer	al Home	of Di	undalk,	Inc.	
7	avec)		23a. Part1. Enter the lisease, incomposition of the listance o	emplications that caused	the death.		922 Wise of dying					1222 Approximate	
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	/Medical Examiner		resulting in death)	Due to r as	a conseque	ence of):	11		20702				
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	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Live	~ L	TIRK	HOSis	•					
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68760	ficate I physics the t	edical		d									
Rox	eath certifi attending for use as	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			F-4				23d. Date of	delivery	
O.	requires that the death cert een signed by the attending rould be detached for use s	Physician/M	in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	1∐Live birth 4□Pregnant at 9□Unknown			Ectopic pregnancy Other <i>(specify)</i>				Month	Day Yea	ar
ري ت	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions	contributing to death but	ut not result	ting in the und	derlying cause give	en in Part I.	236	e. Did tobac	co use contribute	e to the cause of dea	ath?
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	10 1	e Co	25. Was case referred to medical							performed Yes	? death	1?	
>	Physician: r this certificatal director, I	To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2∏E	R/Outpatient	3□ DOA Othe		of Death (Check	_	e 6 X Other (S	Daughte	r's
	ing Ph		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	ry 2	28b. Time of Injury	28c. Injury Work				njury occurred	residenc	
VISION	Attending is death. ector: After by the fune	cati	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	he	At h		M 1 1						
5	ital or A rs after ral Direct led in by	Certification:	4 ☐ Homicide determine	building, etc	c. (Specify)				City	or Town, Si	tate)	Rural Route Numbe	r,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying I	Physician: To the best on aminer: On the basis of and manner sta	examination	ledge, death on and/or inve	occurred at the timestigation, in my op	ne, date and pinion, death	place, and due occurred at the	to the cause e time, date	e(s) and manner and place, and o	as stated. due to the cause(s)	
	Vithii To the comp	ž	29b. Signature and title of certifier	1 m/n	1		29c. License			29d.	Date signed (Mo	onth, Day, Year)	
			· (dward	0111/	ino	1	Doo	620	180	Au	egusto	16,20	07
1	1		30. Name and address of person wh	o completed cause of de	eath (Item 2	3 (Type, P	rint)	Sun	OF NO	1115	RAF	16,20 HURE, M	_
	State	_	31. Date filed (Month, Day, Year) AUG 2, 2	32 egistra	ar's Signatu	re	JORGA TO	Som	May V/C	IVE	DALL		1237
	Registra		nuu 2 2 2	1111/ 1 28	No.	1	40						しよう"/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 12:40 p.M 18, 2007 Jennie Corinne Mayeski August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Bu Burnie Glen Burnie Health & Rehab Center Anne Arundel Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Davs Hours Min. 1 □ M 2 🖾 F Director April 16, 1918 North Carolin 241-24-5846 89 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 TYes 2 No Maryland Anne Arundel Pasadena Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4300 Belle of Georgia Avenue 21122 United States Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Baltimore, Maryland 21215-0036 Specify: White þ 3℃Vidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 years 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of Joseph L. Ballard Addie Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4300 Belle of Georgia Ave. if Health a Pasadena, Md. 21122 Bonnie Hensley - Daughter-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gdns. of Faith 8/22/2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has page 2 s autopsy 2 No 1□ Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 2 No 2 ☐ ER/Outpatient 3□ DOA 1 Tyes 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 27. Manner of Death After t 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after Funeral Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) USHA VEMULAKONDA 32. Régistrar's Signature 31. Date filed (Month, Day, Year) State AUG

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Frederick Wilton Knoel

		1- For State Registrar		Certific	cate of L	Death		,,,	Reg	ı. No.		1 6919
Physici Medical Exam		Decedent's Name (First, Middle)	FREDER	RICK WIL	TON NO	DEL_		_ N	Date of Death Month Jugust 15,	Day 1	Year	3. Time of Death 0642 hrs
		4a. Facility Name (if not institution Harbor Hospital				. City, Town, c Baltimore		*		N/		
Funeral Director		5. Social Security Number 017–44–6264	6. Sex 7. Ag	ge (In yrs. last bii	rthday) Yrs.	Months Da		1.00	Date of Birth	,	Foreig	thplace (State or on untry)Maryland
		Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	or Location							10d. Inside City Limits
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th the Mar 23a or 28s	Il Director	192	26 South Lig		A		212			US	A	
after death with the Maryland in", or items 23a or 28a-f sho	by Funeral	3 Widowed 4 Div	vorced If Yes, Give Year	? 2 X No	If Yes	Decedent of H , specify Cuba es 2 🗶 N	an, Mexican, F		an, etc.)	Specif	hite, etc. y: Whi	
5-0036 led within 72 hours lygiene. other than "natury	Completed I	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12				Usual Occupation of working lift ver			done	TOPS		rary
5-0 Bed wi Hygie other		17. Father's Name (First, Middle,		1 0			18.Mother's	Name (Fir	st, Middle, Ma	aiden Surnar	me)	
21215-0036 und be filed within 7 Mental Hygiene. marked other than	Be		rd Berkley No						Char1			
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ore, ss I an of Hez If itel		20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal from Si	tate crema	itory or other		•				•	Town, State
Baltimore, sermit. Pages I as Department of Hee Important: If ite njury or other tr		4 Donation 5 Other State 21. Signature of Juneral Service	pecify:	Bayvi		emator			0,01			Maryland
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58760, rriffcate be exe	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me of pregnancy	/	death 3					of deliver	y Day Year
that the death certifulation by the attending detached for use as	Physician	1 Yes 2 No 9 Uni	known g Unknown			r (Specify)						
P.O.	þ	Part II. Other significant condit	tions contributing to deat	th but not resulting	ng in the und	lerlying cause	given in Part	1.				the cause of death?
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of Vital Rec ling Physician: The l After this certificate I funeral director, page	욘	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Ini	ent 2 ✓ ER/C	Time of Inju		ury at Work?	<u> </u>	I. Describe ho	esidence 6		
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	Certification:	1 X Natural 5 Pend 2 Accident Inves	ding stigation	Year)		1	Yes 2 N	No				
Divis	Sertific		d not be rmined (Specify)	njury - At home, f	farm, street,	factory, office	building, etc.	28f.	Location (St or Town, Sta		mber or Ru	ral Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical (hysician: To the best of miliner: On the basis of exa	mination and/or								
F 3 F 8	M	29b. Signature and fittle of certific		N			.M.E.			29d. Date si August 1	-	nth, Day, Year)
P	,	30: Name and address of person Susan Hogan MD.	Assistant Medical F	xaminer 1		Street, Ba	Itimore, M	D 21201		<u>.</u>		
Si Regis	72.12.		2. 2007 32. Registra	ar's Signature	Con	de la						
regis	uri.	HUU Z	(COOI PERSON	A A MA	1							

Physician /Medical Examiner
Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	•	For State Registrar	`	State of Ma	ryiana / L		cate of	Death	•	Reg. No		O is		
cia		1. Decedent's Name (First	t, Middle, Last)	OTE	RADO	WEC			2. Date of De Month	eath Da	3 20	Year	3. Time of 7.53	Death M
dica nine		4a. Facility Name (If not in	stitution, give str	eet and number)		4b.	City, Town, o	r Location of Deat	h	40	. County	of Death		
	-	Upper Ches	aneake M	Medical C	enter		Bel Ai	r, Maryla	and		Harf	ord		
al		Upper Ches 5. Social Security Number			(In yrs. last bir	rthday) If L	inder 1 Year	If Under 24 Hrs. Hours Min.	. 8. Date of Bir (Month, Da	th av. Year			lace (State o	or Foreign
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١.	<u>.</u>	11. Marital Status		Armed Forces? 1 ☐ Yes 2 ☒ N		If Yes	specify Cub	lispanic Origin? (S an, Mexican, Puer	to Rican, etc.))-		k, White,		
'	by	1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ D		If Yes, Give Year or Dates:	o .	1□Y	es 2 X No	Specify:			Specify:	Whi	to	
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ľ	_,	19a. Informant's Name/R			198	o. Mailing Ad	dress (Street	and Number or R	ural Route Numb	er, City	or Town,	State, Zip	Code)	
		George Ot	radovec	(husband) 1	11 Un:	it H S	unshine (Court -	Fore	est H	ill,	MD 2	21050
		20a. Method of Disposition	n		20b. Place o	f Disposition	(Name of	ce)	Date	20c. L	ocation -	City or To	wn, State	
		1 XBurial 2 ☐ Crer 4 ☐ Donation 5 ☐ C		noval from State				em. 08/2	23/2007	Ra	1+im	are	Marv	land
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ouce	1	1 6 G). (Lac	andn				ir Road -						087
		23a. Part1. Enter the disc shock, or heart failu	ease, or complica	tions that caused	the death. Do								Approximatinterval Bet	te tween
n		Immediate Cause (Final	ile. List only one		RATION								Onset and	
al		disease or condition resulting in death)	a.	Due to (or as a										
r		0	b.											
	ner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	ate	Due to (or as a	consequence	of):						1,1		
	Examiner	Cause (Disease or injury that initiated events	c.											_
		resulting in death) Last		Due to (or as a	consequence	of):								
-	edical		d.											
- 10	-	IF FEMALE:	200	If you autoomo	of prognoncy									
Ĭ.	Physician/N	23b. Was decedent pregi	riani	If yes, outcome p	2 Fetal deatl		pic pregnanc	y		ì	23d. Date Mor	e of delive nth		Year
	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant at 9□Unknown	ume or death	5 L Otti	er (<i>specify</i>) _							
	H-	Part II. Other significant	conditions contr	ibuting to death bu	it not resulting i	in the underly	ring cause gi	ven in Part I.	23e. Did	tobacco	use contr	ibute to th	ne cause of	death?
	b S	CEREBRO	VASCO	JLAR A	cci Dl	ENT			1 🗆	Yes 2	2 (ZHVO	3 Prob	ably 4 🗆	Unknown
	Completed by								24a. Was	e an	24b V	Mare auto	psy findings	available
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	Be	25. Was case referred to examiner? 1 Yes 2 No		spital:			J DOA Ot	nor:	ath (Check only		- 700			
	٠. ا	27. Manner of Death		1 (2) Inpatier 28a. Date of Injur		utpatient 3 Time of	28c. Inju	4 Li Nursing i	Home 5 ☐ Res				y)	
	ig	/	Pending investigation	(Month, Day	Year)	Injury N		rƙ?]Yes 2 ∐ No		,				
	lica	3 ☐ Suicide 6 ☐	Could not be determined	28e. Place of inju	ry - At home, fa	arm, street, f	actory, office		28f. Location	(Street a	nd Numb	er or Rura	al Route Nur	mber,
	erti	4 ☐ Homicide	dotorrilliod	building, etc	:. (Specify)				City or To	own, Sta	te)			
- [alc	29a. Certifier 1	Certifying Physic	cian: To the best o	of my knowledg	e, death occ	urred at the t	ime, date and plac	e, and due to the	e cause(s) and ma	ınner as s	tated.	
	Medical Certification:	(Check only 2 🗌 🛚	Medical Examine	er: On the basis of and manner sta		nd/or investi	gation, in my	opinion, death occ	curred at the time	e, date a	nd place,	and due to	o the cause((S)
	M	29b. Signature and title o	of certifier	30	CALDIALC			se number	0.7				Day, Year)	
		•	1	OF PITTE	NDING- PHYSICI	AN	D	00 212	OF	0	18/	14/2	007	
		30. Name and address of		pleted cause of de	eath (Item 23a)	(T D-1-1)			- L			1		1/0 - 1
		FRANZ C.				M. E). 5 ⁻	MIDERE	ST CT.	BF	ALTIF	10RE	MDS	11286
Stat		31. Date filed (Month; Da	ty. Year) ==	32. Registra	ar's Signature	4								

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 20, 2007 William Garrett Ritz 7:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Center Randal1stown Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov • 2 , 1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** XXM 2□F Maryland 79 216-24-9820 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 🏋 🕅 No **Funeral Director** MD **Baltimore** Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" can any injury or other traumatic conce. 201 Tollgate Rd. 21117 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ²□No 1950-XXYes 2☐1 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes X2X No Specify: 1952 þ Specify: 3 ☐ Widowed ♣ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Ritz Grace Middleditch ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Holyfield / Daughter 201 Tollgate Rd. Owings Mills, MD 21117 Place of Disposition (Name of cemetery, crematory or other place)
Lake View 20a. Method of Disposition 20c. Location - City or Town, State XIXBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Memorial Park 8/23/07 Sykesville, 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of the eral Service Licens 11605 Reisterstown Rd. Owings Mills, MD21117 trefax 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Hehmown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performe certificate 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 🕶 1 Ampatient 2 ER/Outpatient 3 DOA မှ After this 27. Manne eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours at er death To the Funeral Lirector: completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifiei 1 🗸 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29b. Signature and title of certifier e of death (Item 23a) (Type, Print)
5401 Old Court Road, Randalls town, MD 21133 30. Name and addr of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 3. Registrar's Signature State Registrar

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	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10	d. Inside City Limits
	Many a-fsh ified	żo	MARYLAND BALTI	MORE		BAL'	TIMOR	E.							1 □ Yes 2X No
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	ter de Item	Funeral	11. Marital Status 1XXNever Married 2 Married	12. Was Decedent Armed Forces? 1 Yes 2	•	.5.	was Deced If Yes, spec	cify Cuba	lispanic Origin? an, Mexican, Pu	(Specify ierto Rica	r Yes or No an, etc.)	-	14. Race - A Black, V		
036	ours al al', ol Exam	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	∂(X No	Specify:				Specify:	BLAC	CK
21215-0036	e filed within 72 hours after death with the Maryland it Hygiene. other than "natural", or Items 23a or 28a-f show yent, the Medral Examiner must be notified at	Completed	15. Decedent's E (Specify only highest g	ducation rade completed)		16a. Deced	dent's Usua kind of wo	al Occup	nation during most of	working		16b. K	ind of Busine	ess/Ind	ustry
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lar)	2 sho and I is ma		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address	(Street	and Number or	Rural R	oute Numb	er, City	or Town, Sta	te, Zip	Code)
ره ده	1 and Health em 27 ther to		James T. Roane/S	Son	20h 5	225 Place of Dispo			one Rd.	, Ba			Mary]		
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Spec 21. Signeture of Funeral Service Lice		M'I'	. ZION				-23-(-	ORD, P.A.
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_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying P	Physician: To the best	of my kno	owledge, death	h occurred	at the tir	me, date and pl	ace, and	due to the	cause(s) and manne	er as sta	ated.
	the Ho lin 24 the Fu	Medical	one)	aminer: On the basis of and manner st	ated.	auon and/or in				ccurred	at the time,				
	To 1	Σ	29b. Signature and title of certifier	0 >	,		290	. Licens	e number			29d. Da	ite signed (N	fonth, E	Day, Year)

2

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHILIP MILITELIO, HI) (6 TRIMBLE HILL CT., LUTHER VILLE, MD 21093)

31. Date filed (Month, Day, Year)

32. Registrar's Signature AUG 2 2

07-06479 David Ross

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra Reg. No. 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Time of Death Month Day August 18, 2007 Medical Examiner 1245 hrs DAVID ROSS 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 4316 Groveland Avenue Baltimore N/A 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Days Foreign MARYLAND Hours Min Director 1 X M 2 F 216-60-7563 02/28/1953 Usual Residence of Decedent 4nv 10c. City, Town or Location 10b. County 10d. Inside City Limits s 23a or 28a-f show e notified at once. or 28a-f show 1 XXYes 2 No Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Tatel. If tien 27 is a marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once MARYLAND Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 4316 GROVELAND AVENUE U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White, etc. 1 X Never Married Yes 2XX No 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: BLACK ۵ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12yrs 4yrs **EDUCATOR** BALTO CO SCHOOL SYST. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DAVID ROSS SR HELEN WILLIAMSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Ashe/Mother 4316 Groveland Ave., Baltimore, Maryland 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Itimore, Date 20c. Location - City or Town, State crematory or other place) Burial 2 XXCremation 3 Removal from State partment o METRO CREMATORY 08-24-07 BALTIMORE, MARYLAND Denation 5 Other Specify grature of Funeral Service Licenses 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval /Medical Between Onset and Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year 2 Day Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 V No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be 26.Place of Death (Check only one) examiner? Hospital: Other₄ After this Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 Yes Residence 6 V Other: Scene No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗸 Natural within 24 hours after death To the Fineral Director: the Pending Yes 2 No 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicide (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E August 21, 2007 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day-Year) State 32 Registrar's Signature

DIMINITE REVISION **OCME 2006**

Registrar

OCME

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Rice August 1855 PM 15 2001 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Hopkins 6. Sex The Johns Hospital Bultinore If Under 1 Year | If Under 24 Hrs. N/A 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☑ M 2 □ F Months Days Hours 213-67-9058 May 23 2003 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No MARYLAND N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1113 WEBB COURT 21202 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XX o If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 📉 XIo 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BARRY STEPHON RICE ROCHELLE JACOBS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hillery Hickman/Aunt 1113 Webb Ct., Baltimore, Maryland 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 08-25-07 BALTIMORE, MARYLAND 21. Signatury of Funer Service License 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Gastrointestinal hours Due to (or as a consequence of): tallure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Gastrosch is is IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an autopsy performed? 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mediral Examiner must be notified at

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division or Vital

or Attending

the Hospital

Examine sician and burial-transit attending physician for use as the burial Physician/Medical ģ Completed certificate has Be ၉ within 24 hours after death.

To the Funeral Director: After this Certification:

23b. Was decedent pregnant

Part II.	Other	significant	conditions	contributing to	death	but not	resulting in	the und	erlying cau	se given	in Part

25.	Was case		to	medica
	examiner?	. /		
	1 ☐ Yes	2 No		

27. Manner of Death 1 Natural
2 Accident

5 Pending investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Marssi Wounette pp Physician

29c. License number 00063275 29d. Date signed (Month, Day, Year)

Registrar

Medical

completely filled in by the

31. Date filed (Month, Day, Year) AUG 2 32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

Manssa Bruneth MD 600 N. Wolfe St. Baltimar, MD 31287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9:32 p **Jack Rogers** Aug 19, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** Baltimore 638 Leafydale Terrace 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours 1**⊠x**M 2□ F No. Carolina **Director** 241-50-4874 Apr 13, 1935 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must he marked once. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 XYes 2 □ No N/A **Baltimore** Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 U.S.A. 638 Leafydale Terrace Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 1 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 Xio Specify Specify: Black 3 NVidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Fork Lift-Warehouseman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fannie Rogers Theo Matthews ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 638 Leafydale Terrace Baltimore, Maryland 21208 Terrance Rogers Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 K Burial 2 □ Cremation 3 □ Removal from State 08/25/07 Windsor Mill, Md. King Memorial Park 4 Donation 5 Other (Specify) 21. Sign, alle of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Battimore, Md 21217 23a. Part1. Enter the disease or complications that caused the death. shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cau (Final disease or condition resulting in death) Physician ADENO CARCINOMA METASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Fo the Hospital or Attending Physician: The law requires that the death certificate be executed Exami burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably DIABETES 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an ate has b autopsy performed? 1 Yes 2 10 No certificate director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and manner stated.

Bug NESS 32. Registrar's Signature

M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0059107

CENTER DRIVE REISTOWN

29d. Date signed (Month, Day, Year)

		For State Registrar	State of Maryla		artment of H rtificate of I			giene Reg. No.		16957
Physic /Med		1. Decedent's Name (First, Middle, Las	t)		RIVER	5	2. Date of De Month	Day	Voor	Time of Death
Exami Funeral Director	ner	4a. Facility Name (If not institution, give THE JUHNS HUPK 5. Social Security Number 6. So	INS HOSPITA	rs. last birthday) Yrs.	BAL	TIMORE If Under 24 Hrs. Hours Min.		th ly, Year)	Country)	(State or Foreign
D	or	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo			11000 . 2	1973	10d. I	Inside City Limits 1 XYes 2 No
more, Maryland 21213-50036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show ny or other traumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	MD 10e. Street and Number 835 HILLMAN CT. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12TH 17. Father's Name (First, Middle, Last) MILTON ALEXANDER 19a. Informant's Name/Relationship (IRENE RIVERS/MOT 20a. Method of Disposition 1 Surial 2 Cremation 3 Chemical Control (Specific Specific Sp	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2\subseteq No If Yes, Give Year or Dates: lucation de completed) College (1-4or 5+) JOHNSON Type. Print) HER 20t	16a. Dece (Give life. PA: 19b. Maili 83 D. Place of Dispocemetery, cree	10f. Zip Code 21202 Was Decedent of H If Yes, specify Cuba	specify: ation during most of wor 18. Mother's Nan IRENE R and Number or Ru CT BAL DB)	ne (First, Middle RIVERS ural Route Numb	USA 14. Re Bl Special 16b. Kind of NEW , Maiden Surne MD 21 20c 1 ocation	Business/Industr	ndian, ry de) State T.
BOX 68760, eath certificate be executed. Example 1 permit. Pages 1 a permit. Pages		23a. Part. Enter the disease of comshock, or heart failure. St only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused he de	eath. Do not en	2. Name and Addres 2007–09 ter the mode of dyir	ess of Facility WE EASTERN ng, such as cardiad	SLEY CH AVENUE, c or respiratory a	AVIS, J BALTIM	R. FNRL	. HM.
ecords, P.O. aw requires that the d as been signed by the 2 should be detached	Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of	23c. If yes, outcome pf predictive birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown contributing to death but not the	etal death 3 of death 5	□Ectopic pregnanc □ Other (specify) _ underlying cause giv		1 □ 24a. Was	tobacco use co	b. Were autopsy prior to compl death?	cause of death? y 4 Unknown r findings available etion of cause of
Division or Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To Be		28e. Place of injury - A building, etc. (Sponysician: To the best of my	t home, farm, secify)	of 28c. Inju Wo M 1 L treet, factory, office	ner: 4 ☐ Nursing F ry at rk?] Yes 2 ☐ No ime, date and plac	ath (Check only Home 5 Res 28d. Describe 28f. Location City or To	one) idence 6 GC how injury occ (Street and Nur wn, State)	mber or Rural Rumanner as state	oute Number,
27		(Check only one) Medical Example of Certifier 29b. Signature and title of certifier where 30. Name and address of person who	miner: On the basis of exame and manner stated. Dues, MEDIC	Item 23a) (Type	29c. Licens 70R R E	se number	ourred at the time	29d. Date sig	ned (Month, Da)	y, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Cei	rtificate of De				, No.	
Physicia	ın/	Decedent's Name (First, Middle,Last)	50				2. Date of Death		3. Time of Death
ledical Examir		ADAM 4a. Facility Name (if not institution, give s	root and number		OTHST		August 19,	2007	0337 hrs
		8711 Avondale Road	reet and number)		ty, rown, d rkville	or Location of Deat	1	4c. County of Death Baltimore Cou	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) If I	Jnder 1 Ye	ear If Under 24Hr	s. 8. Date of Birth	(MM/DD/YYYY) 9. Birt	
Director		215-21-7406 1 X M	2_F	24 Yrs. M	onths Da	ys Hours Mir	08/14/	1983 Foreig	untry) MD
aux		10a. State 10b. County	10c. City,	Town or Location	t Asa		91.		10d. Inside City Limits
Aaryland 28a-f show	5	MD BALTIMOR	E PAR			and of a		2.0	1 Yes 2 No
r 28a-	Director	10e. Street and Number		2	Zip Code			g. Citizen of What Cour	
death with the Maryland or items 23a or 28a-f she must be notified at once		8620 DAVID AVENU			040	llspanic Origin? (S		U.S.A	can Indian, Black,
death or item	Funeral	1 X Never Married 2 Married	Armed Forces?			an, Mexican, Puerto		White, etc.	
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21215-0036 Muld be filed within 7 Montal Hygiene. marked other than c event, the M. lim	ပ၂	17. Father's Name (First, Middle, Last) RICHARD		DOTUCTETA			e (First, Middle, M	aiden Surname)	CHARIDO
D 2121 should be fi and Mental 7 is marked	To Be	19a. Informant's Name/Relationship (Type	e, Print)	ROTHSTEIN 19b. Mailing Add		ROCHELL eet and Number or	The second second	per, City or Town, State	SHAPIRO
Tore, MD 2 ages 1 and 2 shou in of Health and A it: If item 27 is in other traumatic		ROCHELLE BYRD /						INGHAM, MD	
ore, ML ss 1 and 2 s of Health a If item 27 her traum		20a. Method of Disposition 1 X Burial 2 Cremation 3	Domestal from State	Place of Disposition crematory or other pl	ace)		Date	20c. Location - City or	·
Baltimore, permit. Pages 1 ar Department of He Important: If ite		4 Donation 5 Other Specify:	\$WI	NICHER WOL	INER	08/	21/2007	BALTIMORE NSON & BRO	, MD
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum.		21. Signature of Funeral Service Licensed	DEN	890	00 RE	s of Facility ISTERSTO	VN ROAD -	PIKESVILL	E, MD 21208
Physician	T	23a. Part I. Enter the disease, or complicate failure. List only one cause on each	ations that caused the death		711				Approximate Interval
/Medical Examiner	- 1	Immediate Cause (Final disease a G	unshot Wounds (2) o		Torso				Between Onset and Death
7		h	e to (or as a consequence o	of):	-4,				
	ne	Sequentially list conditions, if any, leading to immediate Du cause. Enter Underlying Cause	e to (or as a consequence o	of):					
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executed an and al - transit		d. UNPENDED	MENDED	·					
760, icate be ex physician the burial	/Medical	Lance Control	23c. If yes, outcome of preg	inancy				23d. Date of deliver	
	an/N	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal de	eath 3	Ectopic pregr	ancy	100	y Day Year
P.O. Box 68: that the death certifi ned by the attending detached for use as t	Physician/	1 Yes 2 No 9 Unknown	Pregnant at time of de Unknown	eath 5 Other (Specify)				
O. E		Part II. Other significant conditions co	entributing to death but not r	esulting in the under	lying cause	e given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
S, P.C irres that signed d be deta	d by	· · · · · · · · · · · · · · · · · · ·					1 Yes	2 No 3 Prot	pably 4 Unknown
Records, The law require ificate has been si r, page 2 should b	Completed						24a. Was a autops	y prior to o	topsy findings available completion of cause of
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Vital Rec ysician: The his certificate	Be	25. Was case referred to medical examiner?	pital:	1		Other Nurs			
n of Vital iing Physician After this cert funeral directo	£	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 3 28b. Time of Injury	DOA 28c. In	jury at Work?		Residence 6 Othe	r: Scene
- # · ^ 2	ertification:	1 Natural 5 Pending	Aug 19, 2007	0336 hrs	1 —	Yes 2 V No	Subject shot		
Division nal or Attendia rs after death. al Director: A	tilici	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, street, fac	ctory, office	building, etc.	28f. Location (Son Town, St		ural Route Number, City
Divi ospital or , hours after meral Dir	O	4 V Homicide determined	(Specify) School				8711 Avondale	Road, Parkville, MI	
Division To the Hospital or Attent within 24 hours after death To the Finneral Director: completely filled in by the	Medical	one) 2 Medical Examiner: O							
T win	ğ	29b. Signature and title of certifier	nd manner stated.		29c. Lice	nse number		29d. Date signed (Mo	nth, Day, Year)
_		Donne WWir	culi, M.D		0.0	C.M.E.		August 19, 2007	
21		30. Name and address of person who cor	npleted cause of death (Item ssistant Medical Exar		nn Stree	et, Baltimore, N	MD 21201		
St	ate	Donna M. Vincenti, MD As 31. Date filed (Month, Day, Year)	32. Registra's Signati	ure		Daitimore, P	VID 2 1201		
Regist			ALC:	H R					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August Year **Physician** Franklin Rouse, 2007 JUNIOR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burnie Baltimore-Washington Medical Center Glen If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1. M 2□ F North Carolina Director Nov. 22, 1951 212-58-1991 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1 ☐ Yes 2 ☐Xlo Item 27 Is marked other than "natural", or items 23a or 28a-f sl other treumatic event, the Medical Examiner must be notified Director Pasadena Maryland Anne Arundel 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 8138 Armiger Drive U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A 12 Local 24 Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental I F. Rouse, Sr. W. Ham Lawrence Rosa wrence ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Heelth tem 27 Sharon L. Rouse (Wife) 8138 Armiger Drive Pasadenea, Maryland 21122 Department of Heelf Important: If Item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of P 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08/20/07 4 □ Donation 5 □ Other (Specify) Crownsville V.A. Cem Crownsville Maryland 21. Signature of Fune al Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** comany /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse juence of) Examine The law requires that the death certificate be executed attending physician and for use es the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 █ No
9 ☐ Unknown Day 4☐Pregnant at time of death 9☐Unknown signed by the at d be detached for 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Tes 2 No 3 Probably 4 Cunknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy perform certificate 1∏ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient P 27. Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident (Month, Day 5 ☐ Pending investigation nours after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospitel o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

Registrar

BALTO MO

GREENE ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 2007

32. Registrar's Signature

phanie

31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Mary		epailment of 1: Certificate of 1		, ,	4 1 1	
		3	Registrar 1. Decedent's Name (First, Middle, Last)		Dertificate of	Dealit	2. Date of Dea		3. Time of Death
	Physici /Medic		Vernon L. Scheffel				Month August		4:15 P ^M
ķ.	Examin		4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of	Death
	Funeral		Stella Maris Hospice 5. Social Security Number 6. Sex 7. Age (In	yrs. last birth	Timonia nday) If Under 1 Year	if Under 24 Hrs.	8. Date of Birti	Baltim	. Birthplace (State or Foreign
b	Director		216-07-9431 ^{1⊠ M 2□ F} 93	Υ	rs. Months Days	Hours Min.	8. Date of Birth June 24	4, 1914	Maryland
	and w		Usual Residence of Decedent 10a, State 10b, County 10c	c. City, Town	or Location				10d. Inside City Limits
	Maryla f sho	ţo		Baltim					1 □Yes 2□No
	h the or 28a	Directo	10e. Street and Number	Darti	10f. Zip Code			10g. Citizen of Wha	
	ath wil		613 Coleraine Road		2122			USA	
136	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ XYes 2 □ No If Yes, Give Year or Dates: 19		13. Was Decedent of H If Yes, specity Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
2-0036	72 hou "natura	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. D	Decedent's Usual Occup Give kind of work done life. DO NOT use retired	ation during most of work	king	16b. Kind of Busin	ness/Industry
712	within iene. than the Me	dwo	Elementary/Secondary (0-12) College (1-4or 5+)		Mailman	3)	I	U. S. Pos	tal
	be filed ital Hyg id other event, i	Be C	17. Father's Name (First, Middle, Last)				e (First, Middle,	Maiden Surname)	
Maryland	should b ind Ment marked umatic e	2	John Henry Scheffel			Anna M.			<u></u>
Nar			19a. Informant's Name/Relationship (Type. Print) Verna Ann Scheffel Daughte	1	Mailing Address (Street				
re,	es 1 and 2 of Health of Item 27 I r other tre	- 1	20a. Method of Disposition 20		3 Coleraine Disposition (Name of crematory or other place)		Date	20c. Location - Cit	
altimore,	Pages ment of ant: If Its ury or o				Park Cemete	ery 8/23	/2007	Baltimore	, Maryland
Ball	permit. Page Department of Important: If any Injury or once.		21. Signature of Fundar Service Licenses	11290	22. Name and Addre Funeral Ho 1630 Edmon	_{ss of Facility} Ste ome of Ca odson Ave	rling As tonsvil nue: Cat	shton Sch le, Inc. tonsville	wab Witzke . MD 21228
	10	4	23a Part. Enter the lease, or complications that caused the shock, or head ailure. List only one cause on each line.	death. Do no	ot enter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		immediate Cause Final disease or condition resulting in death) END STAGE Due to (or as a condition of the						
	Examiner			isequence of).				
100	pd iii	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	nsequence of):				
	execution and al-tran	Examiner	that initiated events resulting in death) Last C Due to (or as a corr	nsequence of	ř):				
28/60	ficate be executed physician and sthe burial-transit	edical E	d						
_	ertifica ing ph e as th	Medi	if FEMALE:						
O. BOX	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	'	-	23d. Date o Month	
ν, T	requires that the een signed by th nould be detache	by Ph	Part II. Other significant conditions contributing to death but not	t resulting in t	the underlying cause giv	en in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?
ecoras	requir een si nould t						1 D Y	′es 2 No 3[☐ Probably 4 Munknown
ב	The la ate has page 2	Completed						sy prio rmed? dea	re autopsy findings available or to completion of cause of th? Yes 2 \sum No
VII	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2□EB/Outr	patient 3 DOA Oth	er:			WALL HOCKETON
Sion or	D 9 9	⊢ ∤	27. Manner of Death 1 Natural 5 Pending (Month, Day Year 2 Accident investigation	28b. Tir	me of 28c. Injur			ow injury occurred	(Specify) HOSPICE
DIVIS	tal or Atte s after des al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - / building, etc. (Sp.	At home, farm pecify)	n, street, factory, office		28f. Location (S City or Tow	Street and Number on, State)	or Rural Route Number,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	knowledge, mination and/	death occurred at the tir for investigation, in my o	ne, date and place, pinion, death occu	and due to the orred at the time,	cause(s) and mannedate and place, and	er as stated. I due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		29c. Licenson			29d. Date signed (A	Month, Day, Year)
ı	-11	-	30. Name and address of person who completed cause of death	/Itam 22a\ /T	(vne Print)	4372	7	8/20/	0 /
1	5 4		DR. TARIQ MAHMOOD 2300 DULAN			IMONIUM,	MD 2109	3	
	。 Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's S	Signature	Soule			-	
	registr	:II	ALIG 9 9 2007 / 1000	NJ R	7				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Aug 17, 2007 Day **Physician** SMITH 10:00 а м E /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A **Baltimore** 3521 Lucille Avenue If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 K -24-6666 No. Carolina Director Apr 17, 1926 81 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State items 23a or 28a-f show notified at 1 □Yes 2 □ No Director N/A **Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be U.S.A. 3521 Lucille Avenue 21215 Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ∏Yes 2 ☐ Xxo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☐ NX Specify Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event the Man Baltimore City Public Schools Elementary/Secondary (0-12) College (1-4or 5+) **Teachers Aide** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosetta Crown George Cromwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4306 Sihler Oaks Trail Owings Mills, Maryland 21117 Nathan Smith Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ BKurial 2 ☐ Cremation 3 ☐ Removal from State 08/25/07 Baltimore, Maryland Woodlawn Memorial Park 4 Donation 5 Other (Specify) Ture of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Caus (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequestiany liet continued in if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed y physician and is the burial-trans Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical as attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant The law requires that the death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? res 200 No certificate 1□ Yes or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2**X** No Other: 4 ☐ Nursing Home 5 🗖 Residence 6 ☐ Other (Specify) 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Feath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CM) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Pnnt) 5 eens St, Ballinoie 31. Date filed (Month, Day, Year) #82 Registrar's Signature State Registrar AUG 2

DHMH 17 Rev 1/2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				Otate of Mary	_	rtificate of		R	eg. No.	i le	
	BI		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day	Year	ime of Death
	Physicia /Medic		Klaus		Stoeh	r		Aug 19,	2007		35 A
	Examin		4a Facility Name (If not institution, give 10502 Westwood D				4b. City, Town, or L Cheltenl	nam		y of Death nce Georg	ge's
- 10	Funeral Director		400 44 3001		n yrs. last birthday) 9 Yrs.	If Under 1 Yea Months Days		8. Date of Birth Feb 26,	1938	9. Birthplace (S Country) Germany	State or Foreign
Mand	how		Usuef Residence of Decedent 10a. State 10b. County		c. City, Town or Lo						ide City Limits
e X	- -	Sto	Maryland Prince Ge	orge's	Che1	tenham					Yes 21/21/No
h with th	3a or 2 at be no	al Dire	10e. Street and Number 10502 Westwoo	d Drive		10f. Zip Code 20	623		•	What Country? States	
UZU ours after deat	Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturel", or frems 23s or 28s-f ehow any Injury or other traumatic event, the Medical Examiner must be nutitied at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Amped Forces? 1/1/1/Yes 2 ☐ No If Yes, Give Year or Dates:	Vietnam	1□ Yes XX No				ce - American Ind ack, White, etc. fy: White	
2 2 July 72 hc	ne. nen "netur e Medical	To Be Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5+)			upation be during most of work ed) • Officer	king	16b. Kind of B	Business/Industry	
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y y	d Me merk metic	2	19a. Informant's Name/Relationship (T)	vpa Print)	19b. Maili	na Address (Stree	et and Number or Ru	ra/ Route Numbe	r, City or Town	, State, Zip Code)
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Ballillore, Maryland 21213-0020	ent of Hea at: If item ? y or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Onation 5 Other (Specify)	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pi		Date		- City or Town, St	ate
pemit.	Departm Importan any Injur DRCB.		21. Signature Funeral Service Ligens	,	2:	2. Name and Add	ress of FacilityLee a Ferry R	Funeral	Home,	Inc 663	
	ø,	\dashv	23a Part 1. Enter the disease, or composhock, or heart failure. List onty o	Jecations that caused the	7						oximate val Between
E	hysician /Medical xaminer	B	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due	astoma M e to (or as a conse	quence of):	e				t and Death
BOX 66/16/20,	9 6		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue	e to (or as a consec	quence of):					
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hat the	ed by the datache	Physician/M	Parti. Other aignificant conditions co	mileding to dozum but in	or 100g.ting 117 tino 1				res 2∏No		
The law requires that the death ce	is been signed by the attendir	Completed by							an autopsy med?	24b. Were au available compteti of death	prior to on of cause
T and	ate ha	Ĕ						1 🗆 Y	es 2 No	1 ☐ Yes	2□ No
	ortifice ctor, g	Bec	25. Was case referred to medical examiner?					th (Check only o	ne)		
Physic	ar this ce	2	1 ☐ Yes ŽXNo 27. Manner of Death	Hospitat: 1 Inpatient 28a. Date of Injury (Month, Day Yo	2 ER/Outpatie	III 3LI DON		ome 5 Resid			
Lor Attending Physician: T	within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	1XXvatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 4 ☐ Homicide determined		- At home, farm, st	M 1	☐ Yes 2☐ No	28f. Location (S City or Tox		nber or Rural Rou	le Number,
Hospita	within 24 hours after To the Funeral Directory filled in the	edical C	29a. Certifier (Check only one) Certifying Phy	rsician: To the best of m fner: On the basis of ex- and manner stated	amination end/or ir	th occurred at the evestigation, in my	time, date end place opinion, death occu	, and due to the orred at the time,	cause(s) and π date and place	nanner as steted.	ause(s)
o the	vithin Fo the	Me	29b. Signature and title of certifier	1		29c. Lice	nse number		29d. Date sign	ned (Month, Day,	Year)
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	1211		30. Name and address of person who c	Mule n	h (Item 23e) (Type	, Print) 200 Ba	516 CH	- Ste a	200-1	Lurgo M	D 20771
	Sta	te	31. Date filed (Month Day, Year)	2. Registrar's	Signature	All I				J	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2007 4:10A^M PATRICIA KAY SUMAN **AUGUST** 15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore County 31 Mopec Circle Apt. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M XX F 53 Yrs Maryland 217-62-3361 9,1953 Director Nov. Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2X No Director Baltimore County Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 USA 31 Mopec Circle Apt. С by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: White 1 ☐ Yes ★ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXXVo Baltimore, Maryland 21215-0036 X K Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Social Security Adm. 12 yrs. <u>N/</u>A Administrator 18. Mother's Name (First, Middle, Maiden Surname) Injury or other traumatic event, 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked o any Injury or other transment Ruth Kilroy ပ္ Jack Hayes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3321 Augusta Rd. Manchester, Md. 21102 Sabrina Peyton (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 8-20-07 Baltimore, Md. Metro Crematory,Inc. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, he ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): 68760. physician Physician/Medical the attending phase as the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 5 ☐ Other (specify) signed by the a o. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 certificate 1∐ Yes 2. Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Residence 6 Other (Specify) 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3□ DOA 1 ☐ Yes ဥ this ō 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Division Hospital or Attending (Month, Day Year) 5 ☐ Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No death. Funeral Director: A 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 24 hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2

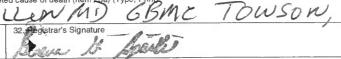
AV

PATRICIA

State Registrar 31 Date filed (Month, Day, AUG

and address of person

2007



who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

altimore, Maryland 21215-0036

€	Phy /M Exa	
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	To the Fundamental Directors. After this certificate has been signed by the attending physician and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** DEAKS 5:26 /1 M WILHER 20011 7 100 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltin 93 pr ti-If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) curity Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. M 2□F 75 Marcilaso 20 22 Director 3607 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Yes 2 □ No Balhana Director MANTAIN 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21215 11512 4907 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Black ۵ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CIMIN 4 CANS 18. Mother's Name (First, Middle, Maiden Surnam 17. Father's Name (First, Middle, Last) Be LUCILLE 1664 19a. Informant's Name/Relationship (Type., Prin ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ocaks C Ind 21 HAM 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 8/20/2007 Woodkur, Woodlawn 4 Donation 5 Dother (Specify) - HAMI FUNORS 22. Name and Address of Facility CHATMA: 21. Signature of Funeral Service Licepsed Al zien STELSKER an.his 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause op each line. Immediate Cause (Final disease or condition resulting in death) OW ian cal ıer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy perfor 25. Was case referred to medical examiner? 26. Place of Death (Check only or Be Hospital: Other: 1 Tes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) Manner of De 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature It Paul St, Suite S, Balhmore MI Year) State AUG 2 2 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Snah Wagartaroo 15 16:24 DM August 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital Daltimore 5. Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑** M 2□ F 5 Director 215-63-3882 Feb. 22, 2002 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d Inside City Limits show r 28a-f show notified at Maryland Howard Columbia 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 9483 Cameldriver Court 21045 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 Is marked other than "naturar", or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or item edical Examiner r Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Medical O College (1-4or 5+) Elementary/Secondary (0-12) None the None item 27 is marked other other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arif U11ah Shah Wynnette Μ. White ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wynnette M. White-Shah (Mother) 9483 Cameldriver Ct., Columbia, MD 21045 20b. Place of Disposition (Name of competery, crematory or other place)
Baftimore Crematory
Loudon Park 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If iter any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/20/07 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1. Enter me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** Iday /Medical Due to for as a consequence of): **Examiner** Congenital Hydro cethalus Sequentially list conditions, if any, leading to in incident cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 5413 Due to for a supplemente of Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1□ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner?
1 X Yes 2 No Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 ☐ Accident 5 Pending investigation Injury ours after death.
neral Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, To the

> State Registrar

31. Date filed (Month, Day, Year) AUG 2 2

Schwartz

Paneu M. Schwark

29b. Signature and title of certifier



and manner stated.

LUD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2

29c. License number

D0060692

29d. Date signed (Month, Day, Year)

August

21287

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2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 14, 2007 10:15A M August William Smith /Medical Ernest 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel General Hospital Annapolis If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year **Funeral** Months Days Hours Sept. Kentucky 9,1934 227-40-8095 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Glen Burnie Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21060 1335 Howard Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 🗓 No Saltimore, Maryland 21215-0036 Specify Specify: Completed by 3 ☐ Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) N/A Elementary/Secondary (0-12) Ellicott Machine Corp. Machinist 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental n and Menta Spicer Louise Goldie ဂ္ Smith Webster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 100 Alview Terrace Glen Burnie, Maryland 21060 of Health Ronald E. Smith (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Pages 1 tment of I ctant: If it 1X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 08/18/07 Oakhall Virginia Downing Cemetery 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tentonitis Physician /Medical Due to (or as a consequence of): Examiner Due to (of as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter U. John grade Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4⊡Pregnant at time of death 5 Other (specify) ed by the a Ö 9□Unknown signed by the σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed 2 No 2. No 1 Yes certificate Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tyes ဥ After this funeral (27. Mann Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) or Attending 1 Natural 5 Pending investigation within 24 hours after deau.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State 31. Date filed (Month, Day, Year

30. Name and address

32. Registrar's Signature

who completed

2007 Agua de Joseph

Registrar

2001 monical PKWY ANNAPOLIS MO 21401

23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 8/19/2007 Marguerite Pijanowski Schroff 5:55 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4704 Ridge Road Nottingham Baltimore 8. Date of Birth (Month, Day, 2/16/1916 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) 1 □ M 2XXF Months Days Hours Director 212-42-0063 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show at ral", or items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2XXNo Director MD Baltimore Nottingham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21236 4704 Ridge Road USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 'natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Retailers permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other the any injury or other traumatic event, the ones. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Regler Thomas Bures ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nottingham, Donald Pijanowski 4704 Ridge Road Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ØCremation 3 ☐ Removal from State Hilltop Service Corp. 8/21/2007 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** muse cardeal disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician a Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 → Known Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to examiner? 1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 this 27. Manual of Death 28a. Date of Injury (Month, Day Year) 28b. Time of I Director: After to in by the funera 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

within 24 hours at To the Funeral C completely filled it

29a. Certifier

(Check only one)

Medical

State Registrar

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

1-28097

Balt., Ud. 21237. Roumo A++ANDRIO

who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) -32. Figistrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 10 2007 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4e) County of Deat Examiner erch Medica Dal en 01 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗙 F Min Director 216-86-9332 AUG. 19, 1974 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notifled at Director 1 X Yes 2 No MD BALTTMORE with the I 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 433 S. BENTALOU ST 21223 filed within 72 hours after death USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 ☒ No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry f Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10th LABORER FACTORY traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be fi Pages 1 and 2 should ٥ DONALD TILLERY DARNICE BYRD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DARNICE BYRD/MOTHER other 1 433 S. BENTALOU ST., BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 5712 O DONNELL ST. Department of I Important: If its any Injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CARMEL 08/20/2007 BALTIMORE, MD 21224 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Acensee 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part Enter the disease shock, or heart failure. omplications that caused only one cause on each line le death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CUTE Ne weeks /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a detached f 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy perform 2 No Physiclan: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 npatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending (Month, Day Year) 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No hin 24 hours after death the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only within 2 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year.

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANDHU

31. Date filed (Mor

1940,

W.

32: Registrar's Signature

8-20-07

BALTIMORE.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 12:01 2007 20, Martha B. Troublefield August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fairfield Nursing Home <u>Crownsville</u> <u> Anne Arundel</u> If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 KF Director 93 214-01-9071 3/18/14 Maryland Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Md Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8034 Woodholme Circle 21122 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes A No Specify: ò Specify 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 0 <u>Bookkeeper</u> Flooring 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rudolph Bartz ို Augusta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph Fischader / Nephew 636 Weyward Drive Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of Hi
Important: If Iter
any Injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Park Cemetery 8/22/07 Baltimore, Maryland 22. Name and Address of FacilityLoudon Park Funeral Home 21. Signature of Funeral Service License 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease shock, or heart failure. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 1 ☐ Yes 2 🗷 No 9□Unknown 9 Unknown Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 1 No 24a Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 20 No P 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of ce 29d. Date signed (Month. Dav. Year) 30. Name and address of pelson who completed cause of death (Item 23a) (Type, Print) 08

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 23:03PM David Joseph Wethern 20 2007 AUGUST /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore SAINT AGNES HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 X M 2 □ F 213-84-6622 45 Jan. 26, 1962 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Department if items 23a or 28a-f show Important: If item 27 is markether than "natural", or items 23a or 28a-f show any injury or orther traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Catonsville Maryland | Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 1525 N. Rolling Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David D. Wethern Karen Ann Carr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4100 Homedale Road; Sykesville, MD 21784
e of Disposition (Name of Date 20c. Location - City or Town, State Thomas Wethern Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 8/22/2007 4 □ Donation 5 □ Other (Specify)

21. Signature of eneral Service License Metro Crematory Catonsville, Maryland 22. Name end Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. NO1290 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 1630 Edmondson Avenue; Catonsville 21228 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 8 DAYS. HYPOXIC RESPIRATORY DISTRESS SECONDARY TO MULTIPLE /Medical Due to (or as a consequence of): SC LEROSIS **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1x Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 TYes 2 □ No M 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Kohit Jam P20659 20 2007 AUGUST

State Registrar DHMH 17 Rev 1/2001

WETHERN

Baltimore, Maryland 21215-0036

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROHIT JAIN

31. Date filed (Month, Day, Year)

AUG

900 CATON AVENUE

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 6 1 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year AUGUST 02:19AM Michael 1 4 1 Watts 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death ARUNDEL MEDICALLENTER BURNIE ANNE GLEN WASHINGTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number A. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 212-70-4761 15,1956 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8117 Gray Stone Lane 21122 U.S.A. . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Dispatcher U.S. Parks Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Watts Potter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne M. Watts (Wife) 8117 Gray Stone Lane Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 14 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Loudon Park Cemetery 08/21/07 Baltimore, Maryland 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) wans Due to (or as a consequence of): Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an 13 0 2 No 25. Was case referred to medica examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

the burial-transit and attending physician as use Por signed by the a ate has t certificate

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

2

Examine

Physician/Medical

þ

Completed

Be

10

Certification:

Medical

27. Manner of Death

1 (▼Natural

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

30. Name and addre

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) AUG 2, 2

2 Accident

5 Pending investigation

6 □ Could not be

determined

2007

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

MICHAEL

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

State Registrar 28b. Time of Injury

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6lpu

29c. License number

1 ☐ Yes 2 ☐ No

Burnes

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

28a. Date of Injury (Month, Day Year)

person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1 40Am **Physician** AUER 200F LARGARET /Medical 4c. County of Death 4a. Facility Name (If not institution give street and number) 4b. City, Town or Location of Death Examiner NNA POL SSISTED NND RUNDAL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, Social Security Number 6 Sex (Month, Day, Year) 4/26/1907 **Funeral** 1 □ M 💥 F 100 Yrs. Connecticut 213-38-3040 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 27 Is marked other than "natural", or Items 23a or 28a-1 show traumatic event, the Madical Examinar must be multiled at 1 ☐ Yes 🏋 No Director Annapolis MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 **IISA** 800 Bestgate Rd. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify: Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DC Government Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Grace Denison Louis T. Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2706 Judson Place Annapolis, MD 21401 Louis T. Bauer Son othar 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ty⊒Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department of Important: If any injury or once. Lincoln Cemetery 8/9/2007 Brentwood, MD 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MONTHS Immediate Cause (Final ASCULAR DOMENTIA Physician disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: . If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 menths? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referre o medical examiner? 26. Place of Death (Check only one) Other (Specify) LIVII Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide

/Medical Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit signed b this certificate has ral director, page 2 To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica After this certification funeral director, p filled in by

DHMH 17 Rev 1/2001

State Registrar

edical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number 046360

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Lyhny MILLERSVILLEMD 2/10

07-06044 Cor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physicia	F	- For State legistrar 1. Decedent's Name (First, Middle,Last)		cate of Death		Reg. No. Date of Death Month Da	v Year	3. Time of Death
lical Exami	ner	Cory Lee Ba	ll	Lu Civ Tours		August 6, 200	7 4c. County of De	
		4a. Facility Name (if not institution, give Easton Memorial Hospital	street and number)	Easton	or Location of Death	100	Talbot	
Francisco		5. Social Security Number 6. Se:	7. Age (In yrs. last b	irthday) If Under 1 Yo		8. Date of Birth(M	IM/DD/YYYY) 9.	Birthplace (State or eign
Funeral Director		214-90-7969 1x	M 2 F 37	Yrs. Months Da	ays Hours Min.	March 22		CountryMaryland
ну		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Location				10d. Inside City Limits
Maryland 28a-f show any d at once.	_	Maryland Carol	ine De	nton	-	L ^M		1 X Yes 2 No
farylar 28a-f s	Director	10e. Street and Number		10f. Zip Code			Citizen of What C	
the N 3a or	ᡖ	1221 Fairfield Co	urt	21629	01:010	Uni	ted Stat	es of Americ nerican Indian, Black,
h with ems 2.	uneral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Spe ban, Mexican, Puerto I	Rican, etc.)	White, etc	
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036 rithin and sene.	Completed	12		elivery Truc	18.Mother's Name	/First Middle Mai	Water (Lompany
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene other than "natural", or items 23a or 28a-f she rent, the Medical Examiner must be notified at once	ပိ	17. Father's Name (First, Middle, Last)				Ann Gern		
212' ould be Mental	o.Be	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing Address (S	treet and Number or F	ural Route Numbe	r, City or Town, S	
MD and 2 shot and 27 is aumatic	-	Grace Ann Ball	Mother	9695 Counci		Cordova,	Maryland Oc. Location - Cit	£ 21625
TOTE, MD 21215-0036 gges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. t: If tien 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Nedical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation 3		ce of Disposition (Name of matory or other place)	i			
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Baltimore, MD 212 permit. Pages 1 and 2 should be Department of Health and Menti. Important: If item 27 is mark injury or other traumatic even		21 Signature of Funeral Service Licer	see	22 Name and Add	ress of Facility Ineral Home	e, P.A.	1 M	aryland 21629
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Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director. After this certifi			cian: To the best of my knowledger:On the basis of examination an	a death occurred at the tir	ne, date and place, ar	d due to the cause	e(s) and manner a	as stated.
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	2	Come W	nconti, M.D.		D.C.M.E.		August 7, 2	007
		30. Name and address of person wh		23a)			L	
		Donna M. Vincenti, MD	Assistant Medical Exam	iner 111 Penn St	reet, Baltimore,	MD 21201		
			32. R istrar's Signatur					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

sician	Registrar	(aryland / De	Certificate of L	Death	2. Date of Deal	eg. No.	11 8.0
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State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month P M Robert Thomas Coleman, Jr. 2007 9:59 August 14, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 23993 McIntosh_Road Hollywood St. Mary's 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1XM 2□F Director 401-88-0977 June 23, Tennessee Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23993 McIntosh Road 20636 Funeral United States 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Staff Analyst U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Thomas Coleman, Sr. Ann Elizabeth Teasley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Natalie Sue Coleman / Wife 23993 McIntosh Road, Hollywood, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 17. 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2007 Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Michael 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each the. P.O. Box 270, Leonardtown, MD 20650 Approximate Interval Between Onset and Death Onset and Death Immediate Cause (Final Physician E SUPPASEAL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afferd death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burnar-transit Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. I 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

AUICE 32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m

, M.D.

29c. License number

24035 Three Notch Road Hollywood, MD 20636

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

obert Joseph	Davidson,	Jr.	
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Physician Robert Joseph Davidson Jr. 4a. Facility Name (if not institution, give street and number) Route 50 @ Route 346 Funeral Director Pure to the first of the product of the prod	State or unk
4a. Facility Name (if not institution, give street and number) Route 50 @ Route 346 Funeral Director Funeral Director Pull Street and Number 10a. State 10b. County 10c. City, Town or Location 10d. Institution of Death Worcester 4b. City, Town, or Location of Death Worcester 4c. County of Death Worcester	ide City Limits
Funeral Director 5. Social Security Number 216-58-8431 1x M 2 F 56 Yrs. 6. Sex 7. Age (In yrs. last birthday) Usual Residence of Decedent 10a. State 10b. County MD Dorchester 10c. City, Town or Location Cambridge 10f. Zip Code 10g. Citizen of What Country? USA 10g. Citizen of What Country? USA	ide City Limits
Usual Residence of Decedent 10a. State 10b. County MD Dorchester Cambridge 10c. City, Town or Location Cambridge 10c. Street and Number 10c. Street and Number 21613 USA	res 2 No
To a. State 10b. County 10c. City, Town or Location 10c. C	res 2 No
505 Gay Street	Disele
505 Gdy Screec 12. Was Decedent Ever in U.S. Armed Forces? 117k 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc.) 14. Race - American India White, etc.	- Disele
를 빌딩 1 X Never Married 2 Married Armed Polices U.I.K	jn, Black,
	unle
during most of working life. DO NOT use retired) Solution College (1-4 or 5+)	unk
Tr. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co	unk
The state of the s	de)
Estelle Wingate girlfriend 505 Gay St., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, S	State
20a. Method of Disposition 20b. Place of Disposition (Name of Cemeter). crematory or other place) Salisbury Crematory 8/7/07 Salisbury, MI	
Pure 1 ga. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 20a. Method of Disposition 1	
700 Locust St., Cambridge, MD 21613	roximate Interva
hysician ledical aminer 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Appr Betw failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ween Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
5 aa .2 UNPENDED	
Fetal death 3 Ectopic pregnancy Section Pregnant	Year
The state of the s	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 24b. Were autopsy performed? 1 Yes 2 No 1 Yes 24c. Place of Death (Check only one)	etion of cause of
1 ✓ Yes 2 No 1 ✓ Yes	2 No
25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scer	ne
24a. Was an autopsy performed? 1	otor vehicle
The part of the control of the contr	oute Number, C
Aug 4, 2007 2030 hrs 204 home, farm, street, factory, office building, etc. 2 Accident 3 Suicide 4 Homicide 4 Homicide 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 2 29d. Date signed (Month, Date in the first interpretable in the first interpretable in the first interpretable investigation in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated. 29d. Date signed (Month, Date in the first interpretable investigation in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated. 29d. Date signed (Month, Date in the first interpretable investigation in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated. 29d. Date signed (Month, Date in the first investigation in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated. 29d. Date signed (Month, Date in the first investigation in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated. 29d. Date signed (Month, Date in the first investigation in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated. 29d. Date signed (Month, Date in the first investigation in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated. 29d. Date signed (Month, Date in the first investigation in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner investigation in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner investigation in my opinion death occurred at the time, date and place, and due to the cause (s) and manner investigation in my opinion in my opinion in my opinion in my opinion in my opinion in my opinion in my opinion investigation in my opinion in my opinion in my opinion in my opi	ise(s)
Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of examination and/or investigation.	ay, Year)
30. Name and address of person who completed cause of death (Item 23a)	
Theodore W. Ning, St., W.D. 765564	
State Registrar 31. Date filed (Mon AUG Year) 8 2007	

Physician /Medical Examiner	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

Funeral Director

	Registrar 1. Decedent's Name (F	First Middle I	l act)			rtificate of	Dealli	2. Date of De	Reg. No.		3. Time of E	Death
	John N.	Daley	ŕ					Month	Day	Year 2007	10:05	a
ıl r	4a. Facility Name (If no	ot institution, g	give street and nu	ımber)		4b. City, Town, o	r Location of Death			County of Deat		
- No	Holy Cros	ss Hosp	oital			Silve	r Spring		М	ontgome	ery	
	5. Social Security Num	iber 6.	Sex	7. Age (In yrs.				8. Date of Bi	rth ay, Year)	9. Birti Co	hplace (State or untry)	Fore
	147-20-691 Usual Residence of De		1⊠M 2□F	79	Yrs.						Jersey	
		Ob. County		10c. City	y, Town or L	ocation					10d. Inside City	
Director	Maryland		Montgo	nery	,	Wheaton					1 ☐ Yes	2 3
ire	10e. Street and Number	er				10f. Zip Code			10g. Citiz	zen of What Co	untry?	
	12613 Ep	ping R	Road			20906				USA		
Funeral	11. Marital Status		Armed F	edent Ever in U.	.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S	pecify Yes or No o Rican, etc.)	0- 1	14. Race - Ame Black, White		
by Fu	1 ☐ Never Married 3 ☐ Widowed 4 [1 ☑ Yes If Yes, G Year or D	2	-46	1 ☐ Yes 2 ☐ No	Specify:			Specify: Whi		
Completed		5. Decedent's only highest of	Education grade completed)	, , , , , , , , , , , , , , , , , , ,	(Give	edent's Usual Occup kind of work done	during most of wor	king	16b. Kir	nd of Business/	Industry	
dwo	Elementary/Seconda	ary (0-12)	College (1-4or 5+)	l .	DO NOT use retire Insurance		r	Pr	ivate		
a	17. Father's Name (Fir	rst, Middle, La	et)				18. Mother's Nan	ne (First, Middle	e, Maiden S	Surname)		
0	George Daley Ter				Teresa	other's Name (First, Middle, Maiden Surname) Presa Griffin						
	19a. Informant's Name	e/Relationship	(Type. Print)		19b. Mail	ing Address (Street	and Number or Ru	ıral Route Numl	ber, City or	r Town, State, 2	Zip Code)	
	Margaret L		y/Wife			3 Epping	Road, Whe		T			
	20a. Method of Disposi 1 Burial 2 □ C 4 □ Donation 5 I	Cremation 3		C-4- C	cemetery, cre	osition (Name of ematory or other pla an's Ceme	tery Augu	Date 1st 13		t on bar		~ ~
ŀ	21. Signature of Funer				ъ-3	2 Name and Addre					Maryla	aa
	- de	we &	3 60	Quy		00 Univer					. MD 20	90
	23a. Part1. Ent. the	disease, or co	mplications that	caused the death						1	Approximate	
- 0	SHOCK, OF THE ATT IS			oach line		itel the mode of dyn	ng, such as cardiac	or respiratory	311001,		Interval Hetw	oon
1	shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death											een
	Immediate Cause (Fin disease or condition resulting in death)		a. Res	each line.	y Fail		ng, such as cardiac	or respiratory a				een
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			1 - For State Registrar	State of Marylan		artment of rtificate of		_	giene Reg. No.	.007	2598)	
77		C.	1. Decedent's Name (First, Middle, La	st)				2. Date of De		V	3. Time of Death	
-30	Physici /Medic		Carolyn Swann	Drury				August	Day	2007	8:30 a ^M	
	Examin		4a. Facility Name (If not institution, giv		-	4b. City, Town,	or Location of Dea			4c. County of Death		
	is a second		21490 Hunters Re	treat Lane	eat Lane		Leonardtown		St. Mary'		3	
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday)	If Under 1 Yea	r If Under 24 Hr		h	9. Birthpl	ace (State or Foreign	
	Director		217-32-3462	□м 2 ∑ F 72	Yrs.	Months Day	s Hours Min	. (Month, Da 08/31/		Couin Maryl		
	70		Usual Residence of Decedent									
	how at		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				11	0d. Inside City Limits	
	a-fs	cto	Maryland St. Mary	's Leo	nardto	wn					1 ☐ Yes 2 🛣 No	
	or 28	ire	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Coun	try?	
	th wi	Funeral Director	21490 Hunters Re	treat Lane		20650			Unit	ed State	es	
	dear F II	ner	11. Marital Status	12 Was Decedent Ever in U	.S. 13.1	Was Decedent of	Hispanic Origin? (Iban, Mexican, Pue	Specify Yes or No	- 1-	4. Race - America Black, White,		
9	after or ite mine	교	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 No If Yes, Give		1 □ Yes 2 DXN		,,		Specify:	510.	
င္တ	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	1 by	3 X Widowed 4 ☐ Divorced	Year or Dates:							ite	
21215-0036	72 h 'natu dical	Completed	15. Decedent's E (Specify only highest gra	ducation ade co <i>mpleted)</i>	16a. Deced (Give	dent's Usual Occ kind of work don	upation e <i>during m</i> ost of w re <i>d</i>)	orking	16b. Kin	d of Business/Inc	lustry	
21	ithin lan " Me	du	Elementary/Secondary (0-12)	College (1-4or 5+)			red)		_			
2	ed w ygier yer th	S	12		Homem	aker	1 40 44 11 1 11	/F:		Home		
P	tal H d oth d oth even	Be	17. Father's Name (First, Middle, Last					ame (First, Middle,	маіаеп З	ourname)		
<u>ya</u>	Men arke	은	Benjamin Gorman S				Anita G	,				
Maryland	2 sh and is m	0 1	19a. Informant's Name/Relationship (1		et and Number or F				,	
2	and ealth n 27 ner tu		James P. Drury/So				Creek Dri				20650	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐	Removal from State	Place of Dispo cemetery, crei	sition (Name of matory or other p	lace)	Date	20c. Loc	ation - City or To	wn, State	
Ĕ	Pag ment ant:		4 □ Donation 5 □ Other (Special		nsfiel	d-Echols	Cre 08/1	15/2007	Char1	otte Ha	11, MD	
at	ppartition in it.		21. Signature of Funeral Service Lice		22	2. Name and Add	ress of Facility B1	insfield	Fun	eral Hom	e, P.A.	
Ш_	9 Q F # 9	10 0	Kyle S. Simons					Road, Leonardtown, MD 20650			20650	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not ent	er the mode of d	ying, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	2500 hou	2000	()	LOGIL			1	Onset and Death	
	/Medical		resulting in death)	Due to (or as a conseq	n nce of):							
ķ.	Examiner		Sequentially list conditions, b.									
	p .=	Examiner	of region belonging to the security fitting	Due to (or as a conseq	Mence of):							
	ecute nd trans	am	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C								
Ö,	cate be executed physician and the burial-transit	<u> </u>	resulting in death) Last	Due to (or as a conseq	uence of):							
38760,	ate b hysic he bi	dical		_ d			.					
~		w	IF FEMALE:							1		
Вох	death certii e attending ed for use a	an/l	23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1☐Live birth 2☐Feta		∃Ectopic pregnar	ıcy		23	3d. Date of delive Month	<u>.</u>	
E	e dea	sici	in the past 12 months? 1 ☐ Yes 2 XNo	4□Pregnant at time of c 9□Unknown	leath 5	Other (specify)				WOITH	Day Year	
P.O.	at the	Physician/M	9 Unknown									
	law requires that the death certif as been signed by the attending 2 should be detached for use a:	by	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause (given in Part I.	2.1			e cause of death?	
Records,	en si							1)2	Yes 2]No 3∏Prob	ably 4 □Unknown	
သွ	law ras be 2 she	Completed						24a. Was	an	24b. Were auto	psy findings available inpletion of cause of	
č	9 ~ e	E						perfo	rmed2	death?	2□ No	
ta	ician: Th certificate ector, pag	Be C	25. Was case referred to medical				26. Place of Do	eath (Check only o				
or Vital	ding Physician: n. After this certific funeral director,	0	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3∐ DOA	Other: 4 \(\sum \) Nursing	Home 5 X Resi	dence 6	□Other (Specifi	<i>(</i>)	
0	g Ph ler th	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. In	jury at	28d. Describe	how injury	occurred		
<u>ö</u>	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigatio		Injury		☐Yes 2☐No					
Division	Atte	ifica	3 Suicide 6 Could not b 4 Homicide determined		ome, farm, str	eet, factory, offic	е	28f. Location (Number or Rura	I Route Number,	
Ö	al or after al Dir	Certification:	Tomode	Building, etc. (Opecin	<i>y</i> /			Only of You	wii, Olale)			
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying P	nysician: To the best of my kno	wledge, deat	h occurred at the	time, date and pla	ce, and due to the	cause(s)	and manner as st	ated.	
	n 24 n 24 ne Fu	Medical	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	and/or in	vestigation, in m	y opinion, death oc	curred at the time,	date and	piace, and due to	tne cause(s)	
	To the l within 2. To the I complet	ğ	29b. Signature and title of certifier				nse number		29d. Date	signed (Month,	Day, Year)	
			· ·	VIAR	1)	H	00557	-51	8	1141	Ut	
,			30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,					1		
			Jennifer Schmidt				e, Suite	205, Leo	nardt	town. MD	20650	
44	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature					,		
			AUR 1 5 2002		. 10							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day Physician **Ethel** Juanita Fairal1 53 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ninsula legional medical NICOMICO 8. Date of Birth (Month, Day Year) Aug 31, 1930 Age (In yrs 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M Maryland 212-26-9654 76 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 'natural', or items 23a or 28a-f show dical Examiner must be notified at Director 1 ☐ Yes 2 → No MD Dorchester East New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5513 Oyster Shell Point Road 21631 IISA Funeral death Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 212 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White þ Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Morris Pumphrey Ruth Upton 2 Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5513 Oyster Shell Point Road E. New Market MD 21631 Department of Health a Important: If item 27 is any injury or other trainonce. Lester Earle Fairall JR SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Metro Crematory 8/6/07 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Aye Ann, MD ala 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or resuiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont Month 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f a∏iJnknown 9 Unknown Part II. Other significant conditions contributing to death put not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>Ş</u> 2 No 3 Probably 4 Unknown 1 TYes page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဂ္ 1 Tes 1 Impatient 2 ER/Outpatient 3 DOA this 27. Manner 28a. Date of Injury (Month, Day Year) Certification: eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 L Hatural Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 0 address of person who completed c 30. Name a se of death (Item 23a) (Type

Registrar

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31. Date fi AUG 0 7 2007 egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Maryland	•	artment of He tificate of D			1011	25991
			Registrar 1. Decedent's Name (First, Middle, Last,				. 2	Reg. I		3. Time of Death
	Physici /Medio		HENRIET		9N1			746455	05,200	7 2:10+M
1	Examir	ier	4a. Facility Name (If not institution, give			4b. City, Town, or I			4c. County of Death	
Н	Funeral		Hebrew Home of S. Social Security Number 6. Securit			Rockv		. Date of Birth	MONTGOM 9. Birth	place (State or Foreign
	Director		019-34-4255	M 20XF 93	Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Yea July 18	71914 °M	lary Land
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	a-fsh	ctor	MD Montg	omery	Si.	Lver Spr	in g			1 ∐ Yes 2 🙀 No
	vith the	Dire	10e. Street and Number			10f. Zip Code	004	10g.	Citizen of What Cou	
	leath v	Funeral Director	3518 Banquo	Drive 12. Was Decedent Ever in U.S	S. 13. V		906	fy Yes or No-	U.S.A.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. item 27 is marked other then "naturel", or items 23a or 28a-1 show other traumatic event, If a Medical Examinar must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 28 No If Yes, Give Year or Dates:	ĺ	Yes, specify Cuban	panic Origin? (Speci , Mexican, Puerto Ri Specify:	can, etc.)	Black, White	, etc.
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced	lent's Usual Occupat	ion iring most of working	16b.	Kind of Business/Ir	ndustry
121	within iene. then "	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+			unselor	*	Montgome	ry Co
	filed within Hygiene.	Be Co	17. Father's Name (First, Middle, Last)	34 1	Gul		18. Mother's Name (ochools on Sumame)	
ylar	should be and Mental Is markad o	To E	Harry Brown		,		Mami	le Wiga	lns	
Maryland	d 2 should be and 7 ls m		19a. Informant's Name/Relationship (Ty Sneryl Cox (Daug			•	nd Number or Rural I Drive, S			
	es 1 and 2 of Health fitem 27 r other tr		20a. Method of Disposition	20b. Pt	ace of Dispo	sition (Name of natory or other place	Dat		Location - City or T	
altimore,	Page nent c		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	iemovai nom state		n Mem Pk	8/10/		ckville	•
Balt	permit. Pag Department Importent: I any injury o once.		21. Signatur of Funeral Service Lights	Sumal	2	Name and Address 46 N.Was	of Facility SI hington			HOME, P.A. ID 20850
			23a. Part1. Enter the disease, or compt shock, or heart failure. List only or	cations that caused the death ne cause on each line.	. Do not ente		_	(12.1		Approximate Interval Between
	Physician /Medical	9 4	Immediate Cause (Final disease or condition resulting in death)	PANCRO	FAI	16 61	ANCE	R		Onset and Death
	Examiner			APT -	2/14	1 HY	DERTO	EN 5	100	
10	p ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ous to (or as a consequ	ence of):					
	xecute and	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ence of);					
68760,	ficate be executed physician and s the burial-transit	edical E	Į,	1						
		Medi	IF FEMALE:							
Box	death certifi re attending p ad for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
P.0	that the de led by the a detached t	Phys	9 ☐ Unknown Part II. Other significant conditions cor		ting in the us	adaabiaa aa aa aa aa	in Death	22a Did tobase	o use contribute to	the course of death?
Records,	The law requires that the death cert te has been signed by the attending tage 2 should be delached for use	ted by	- Takin other significant conditions con	minuting to death but not resu	iding in the ur	identying cause giver	in Fait i.		. /	bably 4 Unknown
	W 7	Completed						24a. Was an autopsy performed 1 Yes 2 127	prior to co	opsy findings available ompletion of cause of 2000
of Vital	Physicien: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	Other	26. Place of Death		6 ☐ Other (Speci	4.1
)	27. Manger of Death		28b. Time of Injury	28c. Injury a		d. Describe how in		<i>ī</i> y)
sion	Attendir death. ctor: Af y the fu	catic	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 □ Ye	es 2 No			
Division	of or Attency after death Director:	ertification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,		et, factory, office	28	f. Location (Street City or Town, Sta	and Number or Run ate)	al Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	ledical C	29a. Certifier 1 Certifying Physical Control 2 Medical Examination	sician: To the best of my knowner: On the basis of examinati and manner states.	vledge, death on and/or inv	occurred at the time estigation, in my opin	, date and place, and nion, death occurred	d due to the cause at the time, date a	(s) and manner as s and place, and due t	stated. o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	4/11	/	29c. License	number	29d. [Date signed (Month,	Day, Year)
	00		panoin	galle.	my	1):	9143	6 176	1642/	05,200/
	30		30 Name and address of person who ce	711121091	190°C	2/2/H	Dures	ERD	Raku	05, 2007 ULE MD 208
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 9 200	32 Registrar's Signatu	re do	who				

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				State of Ma	•	Department of Certificate of	r Health and N of Death	-	giene Reg. No.	7 25992
			1. Decedent's Name (First, Middle, Las		1. 15			2. Date of De		3. Time of Death
	Physici /Medio		Albert J	T. Fic	Lter			Augus	st 2 200	1111
7	Examir		4a. Facility Name (If not institution, give	e street and number)	11		4b. City, Town, or L	4	•	Death
			11010	del Ge	SN H	05P	/ /	Apoli		f At
ı	Funeral Director		165-34-6234	ex 7. Age	e (In yrs. last bin 65	hday) If Under 1 Ye Months Day		8. Date of Birt (Month, Da JULY 26	y, Year)	Birthplace (State or Foreign Country) PENNSYLVANIA
	yland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Mar 19-1 el	Ş	MARYLAND QUEEN AI	NNE'S	CHESTE	R				1 ☐ Yes 2♣ No
	if the	Director	10e. Street and Number			10f. Zip Cod	le		10g. Citizen of Wha	t Country?
	ath w	la l	2006 BRIDGEPOINTE			21619			UNITED S'	
020	s 1 end 2 should be filed within 72 hours after death with the Maryland f Health end Mental Hygiene. I then the marked other then "neturel", or items 23e or 28e-f ehow other treumatic event, the Medical Evantiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 🏿 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 X Yes 2 ☐ N If Yes, Give Year or Dates: 1	10	13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No <i>Specify:</i>	ecity Yes or No Rican, etc.)	1	American Indian, White, etc. WHITE
5-0	72 hc	ğ	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a.	Decedent's Usual Oc (Give kind of work do	cupation one during most of work tired)	cina	16b. Kind of Busin	
21215-0020	filed within Hygiene. other then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	(+)	VERNMENT C		9	UNITED ST	
Þ	il Hygie other	BeC	17. Father's Name (First, Middle, Last)					e (First, Middle,	Maiden Surname)	
Maryland	2 should be f end Mental I is marked of reumatic eve	To E	LAWRENCE FICHTER				MARY SIE	BERT		
lan	2 sho end l is ma		19a. Informant's Name/Relationship (7	Type, Print)	19b.	Mailing Address (Stre	eet and Number or Rui	ral Route Numbe	er, City or Town, Sta	te, Zip Code)
	1 end 2 Health em 27 i		MRS. NANCY JEAN FI	CHTER/WIFE						LAND 21619
Baltimore,	Page nent o ant: if		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemeter	Disposition (Name of y, crematory or other p	place)	Date 7 2007	20c. Location - City STEVENSVI	LLE, MARYLAND
Bal	permit. Pa Departmen Important: any injury.		21. Signature of Funeral Service Licen	w. Os			HELFENBEIN OCK ROAD,			RAL HOME, P.A. D 21619
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that caused one cause on each lin	the death. Do r					Approximate Interval Between
San San	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	· Acuto	0	ndiac	Arrh			Onset and Death
	n #	ner		Ans	Due to (or as a d		05 65	,		
	tificate be executed g physician and as the buriel-transit	Examlner	Sequentially list conditions,	b	Due to (or as a o					
50,	oe exe		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Arto	eriosc	leratic	- Hears	+ 21	seas ce	
68760,	physi the	Aedical	that initiated events resulting in death) Last		Due to (or as a c	onsequence cf):				
×	ا قو ⊈	Me	L	d						
Вох	eath cert attendin I for use	ciar	Taring and the same of the same of					ook Bidd		
P.O.	that the dended by the a	Physician/N	Part II. Other significant conditions co	ontributing to death bu	ut not resulting in	the underlying cause	given in Part I.			oute to the cause of death? ☐ Probably 4 Unknown
Records,	requires been sign should be	Completed by						24a. Was perfo	an autopsy 2.	4b. Were autopsy findings available prior to completion of cause of death?
Œ.	The law ate has page 2	E O						101	Yes 2000	1 □ Yes 2 □ No
Vital	certifica rector, p	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only o	one)	
of \	Physicien: this certific ral director,	မ	1 Yes 2 No	Hospital: 1 Inpatie		patient 3L DOA			dence 6 Other (Specify)
	ding P. h. After t funera	inol.	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	Y Year) 28b. T		njury at Work?	28d. Describe h	how injury occurred	
Division	deat deat ctor: y the	Certification	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju		rm, street, factory, offic	l ☐ Yes 2 ☐ No	28f. Location (S City or Tox		or Rural Route Number,
Ö	5 # 15 E					death coursed at the	e time, date and place,			ar as stated
	To the Hospital within 24 hours To the Funeral completely filled	edical			examination and		ny opinion, death occur			
	To the most	Σ	29b. Signature and title of certifier	00	Depu	29c. Lice	ense number		29d. Date signed (N	fonth, Day, Year)
	H		Millen	K. L.	0,000	DIL	06054	2	8/5/	7
7	13		30. Name and address of person who o	-16/		Type, Print)	- Ame	7	0000	
			31. Date filed (Month, Day, Year)	32. Redistra	ar's Signature	675	Fine	rich	0105	5
	Sta Registr		AUG 07	2007	we to	positi				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	aryland		artment of H rtificate of L			giene Reg. No.		
F	Dhusisi		Decedent's Name (First, Middle, Last)	_				2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic		CLAUDE, CLARENC		LICK	45 Oits Tayon as	Leasting of Dooth	August		2007 County of Death	7:15 P ^M
*	Examin	er	4a. Facility Name (If not institution, give street and numbe St. Mary's Hospital	r)		4b. City, Town, or Leonard				. Mary	e
	Funeral		5. Social Security Number 6. Sex 7. A	Age (In yrs. las	t birthday)	If Under 1 Year Months Days		8. Date of Bir (Month, Da	th		place (State or Foreign
	Director		441-34-2315 ¹ \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	71	Yrs.	Monard Days	1,0010	01/04/			homa
	land ow at		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
	Mary a-f she	ctor	Maryland St. Mary's	Cali	forni	a					1 □Yes 2 No
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	s 23a nust t		23168 Heatherwood Lane 11 Marital Status 12. Was Deceder	nt Ever in II S	13 1	20619	isnanic Origin? (S	necify Ves or No		ted Sta 4. Race - Ameri	
	fter de r item iner r	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ If Yes, Give	6?		Was Decedent of Hi If Yes, specify Cuba		o Rican, etc.)		Black, White,	etc.
2-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	l by	3 ☐ Widowed 4 ☐ Divorced Year or Dates):		1 □ Yes 2] No	Specify:			Specify: Wh:	
5	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Deced (Give life. i	dent's Usual Occupa kind of work done of DO NOT use retired	ation <i>furing most of wor</i> I)	rking	16b. Kin	d of Business/Ir	ndustry
121	withir jene.	omp	Elementary/Secondary (0-12) College (1-40	r 5+)		ion Mecha			U.S	. Milit	ary
Maryland 2	e filec al Hyg I othe vent,	BeC	17. Father's Name (First, Middle, Last)	·			18. Mother's Nan	ne (First, Middle	, Maiden S	Surname)	
<u>yla</u>	ould to	흔	Robert Flick		405 14-00	ng Address (Street a	Sarah Co		or City or	Taura Stata 7	in Codel
<u>a</u>	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship (Type. Print)			,					
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene states are stated other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Virginia G. Flick/ Wife 20a. Method of Disposition	20b. Pla	ce of Dispo	neatherw sition (Name of matory or other plac	e)	Date Date		cation - City or T	and 20619 own, State
E	a - = =	1	1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	le 1	sfiel	d-Echols	Cr. 08/1	8/2007	Char	lotte H	all. MD
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	Some	22	2. Name and Addres	ss of Facility \mathtt{Br}	insfield	l Fun	eral Ho	me, P.A.
	0 0 5 0 0	-	Kyle S. Simons M01206	ed the death		2955 Holls				own, MD	Approximate
	Dhusisian		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final			RHYTHMIA	9, 00011 40 041 414	о посращают,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or a	ARDING as a conseque		2/42 14/43 B					MINDLES
35	Examiner		Sequentially list conditions b.								
-	ed sit	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	as a conseque	ence of):					:	
	be executed sician and burial-transit	Examiner	that initiated events c	as a conseque	ence of):						
68760	ificate be executed g physician and as the burial-transit	edical	d								
_			IF FEMALE:						-1		
Box	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	ne pr pregnan 1 2 □ Fetal o 1 at time of dea	death 3	⊒Ectopic pregnancy ⊒ Other (specify)	1		2	3d. Date of deli ^o Month	very Day Year
o.	at the de by the a tached	hysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown								
S, D	w requires that s been signed to should be deta	by PI	Part II. Other significant conditions contributing to death	but not result	ting in the u	nderlying cause give	en in Part I.				the cause of death?
ord	require sen sig							1	Yes 2L	No 3□Pro	
Vital Records, P	ne law has b	Completed						24a. Was	opsy formed?	24b. Were au prior to c death?	topsy findings available ompletion of cause of
ā			25. Was case referred to medical				26. Place of De	1□ Yes	2No	1 ☐ Yes	2□No
>	yslcia is cert directe	To Be	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpa	atient 2	R/Outpatie	nt 3 DOA Oth	or:	Home 5□Res		3 ☐Other (Spec	cify)
Division or	ding Ph h. After thi funeral		27. Manner of Death 28a. Date of I Natural 5 ☐ Pending (Month,	njury Day Year)	28b. Time o Injury	Wor		28d. Describe	how injur	y occurred	
SIO	ttendi leath. rtor: A the fu	catio	2 Accident investigation	injuny - At hon	ne farm st	M 1 □ reet, factory, office	Yes 2 ☐ No	28f Location	(Street an	d Number or Ru	ral Route Number,
$\overline{\leq}$	l or Attendatter death Director:	Certification:		etc. (Specify)	no, iaiii, st	icot, idotory, office		City or To	own, State)	, and it is a second of the se
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the Funeral director, sampletely filled in by the funeral director.		29a. Certifier (Check only (Check only (Check only) (Check only								
	To the Hos within 24 ho To the Fun completely	Medical	one) and manner			29c. Licens				e signed (Mont)	
	N N N N N N N N N N N N N N N N N N N	-	29b. Signature and title of certifier	D			065665		٨		5 7007
			30. Name and address of person who completed cause of	of death (Item :	23a) (Type,	D: 0	- 6 - 6 - C			2021 11	3 (00)
_			PIETER ESTERIA	istrar's Signat	× 2	24, le	ener Otems	MD	Se	620	
	Sta		31. Date filed (Month, Day, Year) 2007 32 Aeg	strar's Signat	re d	and					
	Regist	aı			1						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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	Physician /Medical Examiner
0	Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt: If item 27 is marked other than "natural", or items 23a or 28a-f show r 28a-f show notified at permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Droportment of Health and Mental Hygiene, and protestart if them 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be an entitle of the protection.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

burial-tra attending physician for use as the buria ate has page 2 s To the Hospital or Attending Physician: ours after death.

neral Director: After this
filled in by the funeral di

Division or Vital Records, P.O. Box 68760,

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 2007 August 4, 11:10 PM Frankie Gilliam 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 3/14/1937 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 X F Days Hours South Carolina 579-52-1384 70 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No Funeral Director Maryland | Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 165 Southdown Road 21037 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Completed by Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Driving School Owner Driver Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edwin DeWolfee Sally McIntyre ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deanna A. Heath/ Daughter 165 Southdown Rd., Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 8/9/07 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Septide Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Caset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 11010(051 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FFMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 **N**0 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Nio 1 Inpatient ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 □ Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

27 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and D50605 erson who completed cause of death (Item 23a) (Type, Print) Y 🗘 2661 Riva Road, Suite 610, Building 600, Annapolis, Maryland 21401 31. Date filed (Month Pay, Ye egistrar's Signature

Registrar

29b. Signature and title of certifier

Be Completed by Funeral Director

70

Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

Physician /Medical

Examiner

Funeral Director

_	Pleas	se Type or Pr	int in Black Maryland / De					_		ble.	
1 - State Registrar				ertifica					g. No.	0.7	25995
1. Decedent's Name Bet		Ann		Grove				2. Date of Death Month August	Day	Year	3. Time of Death 2:15 pm
4a. Facility Name (facility Name)	f not institution, Health	give street and numbe	r)			r Location o	f Death		4c. County Anne		
5. Social Security N 217-40-68 Usual Residence of	833	6. Sex 1 □ M 2 X F	Age (In yrs. last birthd Yrs	Months	or 1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Feb. 24,		Cou	place (State or Foreign Intry) ginia
10a. State MD	10b. County Anne A	rundel	10c. City, Town or Hanov								10d. Inside City Limits 1 □Yes 2 ☒ No
10e. Street and Nur		oad		10f. Z	ip Code	76		10	g. Citizen of		intry?
11. Marital Status 1 Never Marri 3 Widowed		12. Was Deceder Armed Forces ad 1 Yes 2 If Yes, Give Year or Dates	TM0	13. Was Deci If Yes, sp	_	Hispanic Original, Mexican Specify:	jin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		ck, White	can Indian, , etc. nite
(Special Special ondary (0-12)	s Education t grade completed) College (1-4o	(G	ecedent's Us Rive kind of w fe. DO NOT b Tech	ork done use retire	during most d)	of worki	ing	6b. Kind of B		,	
17. Father's Name		ast)	St	afford	,	18. Mother		e (First, Middle, M	aiden Surnai But 1		
19a. Informant's Na Philip Gr		_{ip (Type. Print)} Husband						al Route Number, ver, Mary			p Code)
		3 □ Removal from Stat	20b. Place of Di cemetery Metro C	sposition (Na crematory or remato	ame of other pla ry	ce) {	3/6/		Oc. Location		
21. Signature of Fy	neral Service L	acid A	1	22. Name a Hardes	ty F	ess of Facility uneral	Ho	me P.A.	12 Rid	gely	Ave AnnoMD
23a. Part1. Enter ti shock, or hea Immediate Cause (disease or condition resulting in death)	art failure. List o (Final	complications that cause only one cause on each a. Meta7	ed the death. Do not line.	4 Cas	CLM		cardiac o	or respiratory arre	st,		Approximate Interval Between Onset and Death
cause. Enter Underlying Cause (Disease or injury that initiated events c			is a consequence of):								
		Cd									
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1									very Day Year		
Part II. Other signif	ficant conditio	ns contributing to death	but not resulting in the	e underlying	cause giv	ven in Part I.		23e. Did tob		tribute to	the cause of death? bably 4 □Unknown
		V	V					24a. Was an autopsy perform	ned?	Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
25. Was case refer examiner?	red to medical	Hospitali					of Death	h (Check only one			
1 ☐ Yes 2 🔀 27. Manner of Deat 1 🖼 Natural	th 5 Pending				28c. Inju Wo	ry at rk?		me 5 Reside 28d. Describe ho			ify)
2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investig 6 ☐ Could n determi	ot be 28e. Place of i	njury - At home, farm etc. <i>(Specify)</i>	rm, street, factory, office 28f. Location (St				28f. Location (Str City or Town	nation (Street and Number or Rural Route Number, y or Town, State)		
29a. Certifier (Check only one)		g Physician: To the bearing the basis and manner	of examination and/o								

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day eet Smith Status 28 Crawn Highway Sw Glus Burne MD 2061

31. Date (Red (Month, Day, Year))

32. Registrar's Signature

AUG 0 7 2007

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Year August 6 **Physician** 1:20 A M Jessie Dunham Garrison /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Springhouse @ Westwood Montgomery Bethesda 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours Min 1 ☐ M 2 🕱 F Director 1909 0klahoma 532-50-5841 98 Usual Residence of Decedent Manyland 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits ? Is marked other than "natural", or Items 23s or 28s-f show traumatic event, it a Madical Examinar must be notified at 1 Yes 2 No MD Director Bethesda Montgomery the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20816 USA 5101 Ridgefield Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Completed by 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ellen Owen 2 Roy Dunham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1725 17th Street NW #404 Washington, D.C. 20009 Item 27 Lisa Lias/granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 08/09/07 Beltsville, MD 21. Signature of Funeral Service Lic Going Home Cremation Service P.O. Box 784 MO125[Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Leve 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Hypernatremia /Medical Due to (or as a consequence of): Examiner b. Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of). attending physicien for use as the buria Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) þ signed b Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2√☐ No 3 ☐ Probably 4 ☐ Unknown been signated broaded by Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificete 1 Yes After this certification funeral director, 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6X Other (Specify 1V1ng Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Hospitel or Attending 1 XNatural 2 ☐ Accident Injury 5 Pending after death.

Director: Aft
d in by the fun 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide • Funaral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of pertition 29c. License number 29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

Registrar

Theresa A. Stone, M.D. 1145 19th Street NW Washington, D.C. 20036 31. Date filed (Month, Day, Year) AUG 0 9 2007

30. Name and address of person completed cause of death (Item 23a) (Type, Print)

tous mo

32. Pagistrar's Signature

Blow & Spall

ORIGINAL

MD31162

August 6, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For Ster #24a,25,28a,28c,per phy Decedent's Name (First, Middle, Last)				2. Date of Dea	th	3. Time of Death
Physici Medie		illian Catherine Helewicz				Month 8	r bay 6	2007 804 PM
Examir		a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Dea	th	4c. County	
		tlantic General Hospital		Berlin If Under 1 Year	If Under 24 Hrs	15.5 (5:4)		ester
Funeral Director		7. Age (In y	rs. last birthday) Yrs.	Months Days	Hours Min		, Year) 24	Birthplace (State or Foreign Country) MD
		Jsual Residence of Decedent				10/0/13		
ylanc how		Oa. State 10b. County 10c.	City, Town or Lo	cation				10d. Inside City Limits
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death with the Maryland ms 23s or 28s-f ehow Littust be nutitied at	Director	0e. Street and Number		10f. Zip Code	1		10g. Citizen of USA	What Country?
s 23e	arai	100 White Horse Dr.	VIIS 13 V	2181		Specify Yes or No-		ce - American Indian,
iner	Funeral	Armed Forces?				Specify Yes or No- to Rican, etc.)	Bla	ck, White, etc.
Exam	þ	3 X Widowed 4 ☐ Divorced ff Yes, Give Year or Dates:	•	1 □ Yes 2 🙀 No	Specify:		Speci	^{fy:} White
natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done	during most of we	orking	16b. Kind of E	Business/Industry
76.	Jq I	Elementary/Secondary (0-12) College (1-4or 5+)		OO NOT use retire	d)		Phar	nacv
dygie ther ti	ပိ	11 7. Father's Name (First, Middle, Last)	Seci	retary	18. Mother's Na	me (First, Middle,		
red of	o Be	Joseph Orr				ine E. J		,
Department of Heelih and Mental Hygiene. Important: If item 27 is marked other then "natural", or items eny injury or other treumatic event, the Madical Examinat mone.	ပ္	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or F	lurai Route Numbe	r. City or Town	, State, Zip Code)
27 ls		Kathy McEntee / daughter	414	Powhaton	Hill Pla	ace, Mana	kin-Sa	bot, VA 23103
item r othe		20a. Method of Disposition 20l 1 State 2 □ Cremation 3 □ Removal from State	b. Place of Dispo cemetery, cren	sition (Name of natory or other pla	ce)	Date	20c. Location	- City or Town, State
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	ē	Sequentially list conditions, if b. Due to (or as a concause. Enter Underlying	sequence of):					
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icien a		resulting in death) Last Due to (or as a con	sequence of):					
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atten for u	clan	in the past 12 months?	etal death 3	Ectopic pregnanc Other (specify) _	у			onth Day Year
y the	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown						
	P P	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	obacco use co	ntribute to the cause of death?
ngis ue eq pin	ed b					1,200	res 2□No	3 ☐ Probably 4 ☐ Unknown
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To the complet	Med	one) and manner stated. 29b. Signature and title of certifier		29c. Licen	se number		29d. Date sign	ed (Month. Day, Year)
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	11	30. Name and address of person who completed cause of death	(Item 23a) (Type,	Drint)			0	, , ,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month OK NYO HAN 2129 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Memorial Easton lalbot 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Hours 1 □ M 2 X F Director 521-91-3287 82 OCT.3,1924 KOREA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No TALBOT TRAPPE Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3859 SEYMOUR DRIVE 21673 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Completed by Specify: 3 Widowed 4 □ Divorced ASTAN 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Health and Mental H tant: If Item 27 Is marked oth Be UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KYE S. LEE/ DAUGHTER 3859 SEYMOUR DRIVE, TRAPPE, MD. 21673 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of h Important: If Ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION | 8-4-07 STEVENSVILLE, MD 4 Donation 5 Dother (Specify) CENTER 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician LONONAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading Limited at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 | Yes 2 | No 3 | Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed' 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attendenthin 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parket St Deston MQ21629 RMC 9 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

32. Registrar's Signature

AUG 07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:35P M 1 Ó 2007 Thomas Brome Howard August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Charlotte Hall Veterans Home Charlotte Hall If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6 Sex 5. Social Security Number **Funeral** Days Hours 1 X M 2 □ F July 20 1921 Maryland 219-18-5886 86 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Marvland St. Mary's Ridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20680 United States 48868 Curley's Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Black, White, etc. of filed within 72 hours after de Il Hygiene. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 💢 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Surveying Surveyor and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jeannette Elinor Brome John Spence Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 54 St. Mary's City, Maryland 20686 nt of Health a Mary Stiles Howard / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If ite 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Charlotte Hall, MD. Brinsfield-Echols Cre8/14/2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home PA. 22955 Hollywood Road Leonardtown, Maryland 20650 M0 <u>⊯ ∪ 6</u> Kyle S. Simons 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a con-**Examiner** Sequentially list conditions, if any, leading to himediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown sate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 2 1 certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: Hospital: 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 ☐ Yes 1 🔲 Inpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? Medical Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide

the death certificate be executed Box 68760, P.O. Division or Vital Records, s after death. by ö filled in within 24 hours a

death with the

Baltimore, Maryland 21215-0036

Pages .

29b. Signature and title

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

D0057574

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 Hospital Road, Prince Frederick, MD 20678 Ahmed Heshmat, M.D.

AUG 1 5 2007

29a. Certifier

(Check only one)